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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

ATLANTIC SHORE SURGICAL ASSOCIATES, Plaintiff, v. QUALCARE, as Administrators and AFFILIATED PHYSICIANS AND EMPLOYERS HEALTH PLAN, JOHN AND JANE DOES 1-10 and ABC CORPORATIONS 1-10, Defendants.	Civil Case No.: 3:17-cv-13109-FLW-LHG Civil Action **CERTIFICATION OF STEPHANIE ALFONSO IN SUPPORT OF DEFENDANT AFFILIATED'S MOTION TO DISMISS COMPLAINT**

Stephanie Alfonso, of full age, hereby certifies as follows:

1. I am employed by Concord Management Resources, as the Director of Vendor Delegation and Operational Oversight. Prior to that I was employed by QualCare, Inc. ("QualCare"), as the Director of Vendor Delegation and Operational Oversight. In that capacity, I had regular access to Defendant The Affiliated Physicians and Employers Health Plan ("Defendant Plan") documents, including enrollment and claims information that apply to instances when QualCare acts as the designated plan or claims administrator. Based on a review of records prepared and maintained by QualCare in the ordinary course of its business, I offer this certification in support of Defendant Plan's motion to dismiss Plaintiff's Complaint. I have

personal knowledge of the facts set forth below except in those instances where I make the statement based on information and belief.

2. According to the Complaint, on or about April 14, 2016, a patient identified in the Complaint as MJK underwent surgery performed by Plaintiff, which does not participate in the Defendant Plan's provider network.

3. Plaintiff submitted to the Defendant Plan charges of $66,008.88 for the surgery.

4. When the Plaintiff performed the above surgical services, MJK was enrolled in healthcare coverage through the Defendant Plan, a self-insured employee welfare benefit plan governed by ERISA. Defendant Plan's Summary Plan Description effective January 1, 2004, is attached hereto as **Exhibit A.**

5. On or about November 11, 2016, MJK executed a written assignment of benefits in favor of Plaintiff. A true and correct copy of the assignment of benefits signed by MJK on November 11, 2016, is attached hereto as **Exhibit B.**

6. I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

STEPHANIE ALFONSO

Dated: January 3, 2018

14207923v1 (23198.010)

EXHIBIT A

Affiliated Physicians & Employers Health Plan

A NJ Self-Insured MEWA

Summary Plan Description

Plan Effective Date:
January 1, 2004
Revised: August 1, 2014

Table of Contents

INTRODUCTION

This document provides the terms and Conditions for eligibility and benefits. This document provides highlights about the Affiliated Physicians and Employers Health Plan (hereinafter the "Plan"). The Plan is being sponsored by the APEHP Health Plan Trust (hereinafter the "Trust"). This document is intended to be a comprehensive description of the participation requirements and available benefits under the Plan. Please keep it for Your reference. When it states "Plan Document" or "Summary Plan Description" (or SPD), it is referring to this document. Benefits under the Plan are provided through a multiple Employer welfare arrangement (or "MEWA"). A MEWA is an arrangement, recognized in both federal and state law, whereby multiple Employers join together to self-insure some or all of its welfare benefits of their Employees.

This is **not an insured benefit Plan**. The benefits described in this booklet or any rider attached hereto are **self-insured** by the Trust.

This is a fully assessable benefit Plan. In event that the Trust is unable to pay its obligations, enrolled participants of Trust shall be required to contribute on a pro rata earned contribution basis the funds necessary to meet any unfulfilled obligations.

The Trust reserves the right to change, modify and amend the Plan at any time and from time-to-time, in whole or in part, as well as any or all of the provisions of the Plan, without advance notice subject to any outstanding contractual agreements or requirements of law. Any amendments to the Plan may be effected by a written resolution adopted by the Trust. Changes in the Plan may occur in any or all parts of the Plan including, but not limited to benefit coverage, Deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if expenses were incurred as a result of an accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Employer or Employee(s) of a group intentionally misrepresent a material fact or fail to report information, this may be used as the basis to rescind, terminate or modify the entire group's coverage or coverage for a particular Employee. Rescind means that the coverage was never in effect.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan's rights and benefits for covered Employees and their Dependent(s) and is divided into the following parts:

Eligibility, Funding, Effective Date Provisions. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Medical Benefits – What's Covered. Details what charges are **not** covered.

Your Benefits. Explains when the benefit applies and the types of charges covered.

What's Not Covered?- Plan Exclusions. Details what charges are **not** covered.

Medical Management Services. The purpose of the program is to determine what is payable by the Plan and to curb any unnecessary and excessive charges.

This part should be read carefully since each Plan Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

How to Submit/File a Claim/Appeals/Grievance Procedures. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Explains the Plan payment order when a person is covered under more than one Plan.

Third Party Recovery Provision. Explains this Plan's right to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuing Coverage. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Rights. Explains the Plan's structure and the Covered Persons' rights under the Plan.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

IMPORTANT INFORMATION

NOTICE OF STATE REQUIREMENTS

The Affiliated Physicians and Employers Master Trust is not an insurance company and does not participate in any of the guarantee funds created by New Jersey Law. These funds will not pay Your claims or protect Your assets if the Affiliated Physicians and Employers Master Trust becomes insolvent and is unable to make payments as promised.

The health benefits that You have purchased or are applying to purchase are being issued by a Self-Funded Multiple Employer Welfare Arrangement ("MEWA").

For additional information about the Affiliated Physicians and Employers Health Plan ("MEWA") You should ask questions of Your Plan Administrator at (888) 670-8135.

NOTICE OF FEDERAL REQUIREMENTS

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the *Women's Health and Cancer Rights Act of 1998* (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast upon which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema

If You would like more information on WHCRA benefits, please contact Your Plan administrator on the number on Your ID card.

COVERAGE FOR MATERNITY HOSPITAL STAY

Group Health Plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

Please review this Plan for further details on the specific coverage available to You and Your Dependents.

NOTICE REGARDING PROVIDER DIRECTORIES AND PROVIDER NETWORKS

If Your Plan utilizes a network of Providers, You can view them online at www.qualcareinc.com\qcmewa or call Customer Service at 888-670-8135. Your Participating Provider network consists of a group of local Physicians, including Hospitals, of varied specialties as well as general practice, who are contracted with the QualCare, Inc. or the Affiliated Physicians and Employers Health Plan.

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If You were covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed services leave, whichever is shorter, if You pay any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for Active Employees. If the leave is longer than 30 days, the required contribution will be higher, but will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage available under COBRA Continuation Coverage.

Whether or not You elect continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day You return to active employment with the Employer if You are released under honorable Conditions and You return to employment:

- On the first full business day following completion of Your military service for a leave of 30 days or less;
- Within 14 days of completing Your military service for a leave of 31 to 180 days; or
- Within 90 days of completing Your military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans Administration to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continuous under this Plan. Eligibility Waiting Period (if any) will be waived as if You had been continuously covered under this Plan from Your original Effective Date of coverage. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by Your military service, as determined by the VA. For complete information regarding Your rights under USERRA, contact Your Employer.

Children's Health Insurance Program Reauthorization Act of 2009 ("CHIP)

The purpose of CHIP is to provide funding for Children's Health Insurance under Medicaid and State Children's Programs and to allow a group health Plan to permit special enrollment for eligible but not enrolled Employees or Dependent Children who either:

(1) lose coverage under a Medicaid or a State Children's Health Insurance Plan (SCHIP) under titles XIX and XXI of the Social Security Act, respectively, or

(2) become eligible for Group Health Plan premium assistance under Medicaid or SCHIP (Special Enrollment Right).

The Member or Dependent must request coverage no later than sixty (60) days after the date eligibility is lost or the date Member and/or Dependent is determined to be eligible for State contribution assistance.

Qualified Medical Child Support Orders

Eligible Dependent Children who are required to be enrolled in the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) may be enrolled midyear. Upon receipt of an order (from a court or from an administrative agency) requiring enrollment of an eligible Dependent Child, the Member will be notified if the order constitutes a Qualified Medical Child Support Order (QMCSO) as required under federal law.

For more information about QMSCOs, contact the Plan at 1- 888-670-8135. Participants and beneficiaries in the Plan may obtain a copy of the Plan's QMCSO procedures upon request and without charge

Michelle' Law

This law affects all ERISA-qualified Plans and ensures that a Dependent college student requiring a Medically Necessary and Appropriate leave of absence from a postsecondary educational institution due to a serious Illness or Injury, can continue to receive coverage through their family's medical Plan even if they are unable to maintain their full-time student status. Written certification from a treating Physician must verify that the Dependent college student is suffering from a serious Illness or Injury and that the leave of absence is Medically Necessary and Appropriate. This law prevents a Group Health Plan from removing coverage from a "Dependent Child" due to a "Medically Necessary and Appropriate leave of absence" before the earlier of:

(a) one year after the first day of the Medically Necessary and Appropriate leave of absence; or
(b) the date on which the coverage under the Plan would otherwise terminate.

CONFIDENTIALITY/ HIPAA PRIVACY

The following provisions are intended to comply with applicable requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Disclosure by Plan to Plan Sponsor

The Plan may take the following actions only upon receipt of a Plan amendment certification:

(1) Disclose protected health information to the Plan Sponsor.

(2) Provide for or permit the disclosure of protected health information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan.

Use and Disclosure by Plan Sponsor

The Plan Sponsor may use or disclose protected health information received from the Plan to the extent such use is consistent with the provisions of this HIPAA Privacy Section or the privacy rule.

Obligations of Plan Sponsor

The Plan Sponsor shall have the following obligations:

- Ensure that:
  - Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and Conditions that apply to the Plan Sponsor with respect to such information; and
  - Adequate separation between the Plan and the Plan Sponsor is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

- Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

- Not use or disclose protected health information received from the Plan:
  - For employment-related actions and decisions; or
  - In connection with any other benefit or Employee benefit Plan of the Plan Sponsor.

- Report to the Plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

- Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
  - For access to the individual;
  - For amendment and incorporate any amendments to protected health information received from the Plan; and
  - To provide an accounting of disclosures.
  - Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.

- Return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Provide protected health information only to those individuals, under the control of the Plan Sponsor who perform administrative functions for the Plan; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.

- Provide protected health information only to those entities required to receive the information in order to maintain the Plan (i.e. Claim Administrator, case management vendor, Pharmacy benefit manager, claim subrogation vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the Plan).

- Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

- Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident of which it becomes aware.

Exceptions

Notwithstanding any other provision of this HIPAA Privacy Section, the Plan (or a health insurance issuer or HMO with respect to the Plan) may:

(1) Disclose summary health information to the Plan Sponsor:

a. If the Plan Sponsor requests it for the purpose of:

i. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

ii. Modifying, amending, or terminating the Plan;

(2) Disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan;

(3) Use or disclose protected health information:

a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;

b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or,

c. As otherwise permitted or required by the privacy rule.

ELIGIBILITY, FUNDING, AND EFFECTIVE DATE PROVISIONS

WHO IS ELIGIBLE?

Eligible Classes of Employees

(1) All Active Employees of a Participant of the Trust

Employees become eligible for coverage on:

(1) The Effective Date in which Your Employer enrolls in this Plan if You were employed on that date; or

(2) The first of the month following their first day of employment (subject to the Conditions listed below).

However, Plan coverage is not automatic. The Employee has to timely enroll in the Plan to be covered as an Active Employee.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she meets the following requirements:

(1) is a permanent Full-Time Employee of a Participant of the Trust, who works a minimum of 24 hours per week, if Your Employer offers benefits to its full-time Employees.
(2) is in a class eligible for coverage.
(3) completes the Employee Waiting Period as determined by Your Employer (which cannot exceed 90 days). However, Plan coverage is not automatic. The Employee has to timely enroll in the Plan to be covered as an Active Employee.

However, Plan coverage is not automatic. The Employee has to timely enroll in the Plan to be covered as an Active Employee. You must provide proof of employment status, such as a payroll stub and You must complete an enrollment form.

For purposes of eligibility for coverage, Full-Time Employees who are absent because of health Conditions are treated as if they are actively at work, and leaves of absence that qualify under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA) are treated as periods of active employment to the extent such treatment is required and applicable to the Employer under such laws. Notwithstanding the foregoing, a newly hired or newly eligible Employee must report to work for the Employer in order for any coverage under the Plan to become effective.

Under the Plan, You can elect to cover Your ***eligible Dependents*** for certain coverage (see below). You may make this election only when You are first eligible for this coverage, during the Annual Open Enrollment Period or when You experience a qualified change or qualifying event as described in the Special Enrollment Period section.

Eligible Classes of Dependents

A Dependent is eligible for coverage under this Plan as follows, provided that Your Employer offers Dependent coverage:

A Dependent is any one of the following persons:

(1) **Legal Spouse.** The term *"Spouse"* shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator requires a certified copy of a marriage certificate.
(2) **Domestic Partner.** Domestic Partners, of any gender, who have been living in a committed exclusive relationship of mutual caring and support with the covered Employee for a period of 12 months, who intend for the Domestic Partnership to be permanent are covered under this Plan, provided that they meet the following proof requirements. It is required that You provide three documents evidencing the commitment of the relationship. The following documentation for coverage of a domestic partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Employee's will; durable power of attorney for healthcare or financial management; Joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party. You may be required to sign an agreement with the Plan that You provide the Plan with notice within 31 days of a break in the Domestic Partnership.
(3) **Civil Union Partner.** Pursuant to P.L. 2006, c.103. Civil Union couples are granted all of the same rights as married couple. The Plan requires a copy of the Civil Union Certificate. Civil Union couples do not have to meet domestic partner guidelines or provide proof requirements of Domestic Partnership.
(4) **Unmarried Child(ren) up to Age 31.** A Dependent is eligible for coverage up to age 31 from the first day that he or she meets the Dependent definition below if they are between the age of 26 and 31. These Dependents will be subject to 102% of the single healthcare fee rate charged for the Plan in which they are enrolled in and will be covered until their 31st birthday or until the last day of the month for which the required payment has been made, whichever comes first.

(5) **Child(ren)** who have not attained age 26 will be eligible for coverage under the Plan. Such Children must be unmarried and be primarily Dependent upon the covered Employee for support and maintenance and do not have to be eligible to declare the Dependent Child as a tax Dependent under IRC Section 152 (Dependent defined) on the Employee's tax return as opposed to actually declaring the Dependent Child on the Employee's tax return. Documentation showing eligibility, including but not limited to, birth certificates, proof of full time college student status, marriage certificates, tax records, records of relevant legal proceedings, separation and divorce decrees must be provided to the Human Resource Department.

The term "*Children*" or "*Child*" shall include natural Children, adopted Children, Civil Union Partner's Children, foster Children or Children placed with a covered Employee in anticipation of adoption or of the Child's becoming a Member's foster Child. Step-Children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household

The phrase "*Child placed with a covered Employee in anticipation of adoption*" refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption.

The term "*placed*" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. Coverage of these pre-adoptive Children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. The Child must otherwise be available for adoption and the legal process must have commenced.

The phrase "*primarily Dependent upon*" shall mean Dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

If a covered Employee is the Legal Guardian of an unmarried Child or Children, these Children may be enrolled in this Plan as covered Dependents.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical Child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these Children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical Child support order procedures are available upon request.

(6) **Legal Guardianship.** Should the covered Employee have a court-appointed Legal Guardianship and is within 30 days of the date Legal Guardianship is granted, coverage for the Child becomes effective the date the Legal Guardianship is granted. A Child for whom the Employee acquires Legal Guardianship, but does not apply to enroll until more than 30 days after the date Legal Guardianship is granted, will not be eligible until the next Annual Enrollment Period.

(7) A covered Dependent Child who reaches the limiting age and is **Totally Disabled,** incapable of self-sustaining employment by reason of mental or physical handicap, primarily Dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two-year period, the Plan may require subsequent proof not more than once each year. The Plan reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

ELIGIBILITY LIMITATIONS

The following persons are excluded as Dependents:

(1) The divorced former spouse of the Employee.
(2) Any person who is on active duty in any military service of any country.
(3) Foster Children.
(4) Other individuals living in the covered Employee's home, but who are not eligible as defined.
(5) Dependents of Dependent Children.

Eligibility Requirements for Dependent Coverage. A family Member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family Member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by the Plan.

WHO PAYS THE COST OF COVERAGE

Each Employer shares the cost of the coverage under the Plan with the covered Employee.

Coverage may be contributory. A coverage is contributory when the Employee must pay all or part of the cost. If Your Plan is contributory, You must fill out an Enrollment Form. By signing the Enrollment Form, You are agreeing to pay Your part of the cost as agreed to by You and Your Employer. Each Employer sets the level of any Employee contributions. Your Employer reserves the right to change the level of Employee contributions at any time. Check with Your Employer to obtain details on Your contributions

ENROLLMENT

HOW TO ENROLL

Each year during the Annual Open Enrollment Period, Your Employer will provide You with information on the Benefit Program for the upcoming year. You will be allowed to change Your level of coverage at that time, subject to Plan guidelines.

An Annual Open Enrollment Period is the one-month period beginning immediately before the group's Renewal Date. The Employees of Participants of the Trust will be notified about the benefit Plan(s) being offered. If multiple benefit Plans are offered within this program, all Plans must have the same Annual Open Enrollment Period. The Effective Date of coverage for Employees of a Participating Member of the Trust who enroll during open enrollment will be the first day of the Benefit Plan Year following the Annual Open Enrollment Period.

(1) Benefit Plan changes are only available at the Groups Renewal Date.
(2) Benefit Plan changes must be received by the Plan Administrator within 30 days of the Renewal Date.
(3) All benefit Plan changes must be submitted in writing.

WHEN YOUR COVERAGE BEGINS

If You are a new Employee of a Participating Member of the Trust enrolling after the Annual Open Enrollment Period, Your elections become effective as follows:

(1) Full-Time Employee of a Participating Member of the Trust — Coverage becomes effective on the first day of the month following either;

- Your date of hire, if Your Employer does not impose a Waiting Period; or
- completion of Your Employer's Waiting Period requirement.

If Your status changes from an ineligible Employee of a Participating Member of the Trust to one who is eligible to participate in the Plan, coverage is available on the first day of the month that falls on or follows the date of Your change in status, as long as You have satisfied the initial Waiting Period, if any, and completed an enrollment form.

The Waiting Period varies by Employer but cannot exceed 90 days. The Waiting Period is defined as the number of days of continuous employment after which an Employee of a Participating Member of the Trust becomes eligible for coverage under the Plan. Each Employer may have different Employee Waiting Periods. Check with Your Employer to get details on Your Waiting Period.

BENEFIT YEAR

Your Benefit Year is the date by which all benefits are tracked.

Definitions You Need to Know

Benefit Year is the twelve (12) month period beginning on January 1st. This is the date by which all Plan Deductibles, Plan maximums, visit maximums, etc.) are tracked. Each Benefit Year Your Plan maximums and Deductibles will be reset.

ENROLLMENT REQUIREMENTS FOR NEWBORN CHILDREN

Covering a newborn Child of a covered Employee **who has Dependent coverage:** Newborn Children shall be covered from birth for thirty-one (31) days if You already have Dependent coverage, but an enrollment form for the Child **must** be completed to formally add the Child as a Dependent or coverage will be terminated after 31 days. Charges for covered Nursery care while in the Hospital will be applied toward the Plan of the covered parent.

Covering a newborn Child of a covered Employee **who does NOT have Dependent coverage:** If the newborn Child is required to be enrolled and is not enrolled in the Plan on a timely basis, there will be no payment from the Plan except for routine Nursery care while in the Hospital, and the covered parent will be responsible for all costs. Charges for covered Nursery care while in the Hospital will be applied toward the Plan of the covered parent. Once discharged, a newborn Child of a covered Employee must be enrolled in the Plan within thirty one (31) days of the Child's birth in order for any additional services to be covered. If an enrollment form is not submitted by the 32nd day following birth, the newborn Child will only be eligible for enrollment during the next Annual Open Enrollment Period.

If You did not have Dependent coverage under the Plan, **You must enroll a newborn Child by completing an enrollment form** as a Dependent under the Plan within thirty-one (31) days of the Child's birth, in order for coverage of Sickness or Injury, including Medically Necessary and Appropriate care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity to be covered.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during the Annual Open Enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

WHEN YOU CAN MAKE CHANGES TO YOUR COVERAGE - SPECIAL ENROLLMENT PERIODS

You may make changes to Your coverage each year during Your Annual Open Enrollment Period. These changes generally remain in effect for 12 consecutive months. However, You may also change Your coverage elections during the year in the situations listed below provided that the Plan is notified within 31 days of the event.

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first day of the month following the qualifying event. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following Conditions is met:

(a) The Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or Employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days of the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Certain special enrollment rights also exist for Employees or Dependents who lose coverage under the Children's Health Insurance under Medicaid and State Children's Programs (CHIP).

Dependent Beneficiaries. Generally, a covered Employee must enroll Dependents during the Annual Open Enrollment Period. Special enrollment is permitted if an Employee enrolls Dependents due to a qualifying event. The coverage for the Dependent will become effective on the following dates corresponding to the qualifying event:

- In the case of marriage, not later than the first day of the first calendar month beginning after the completed request for enrollment is received;
- In the case of a Dependent's birth, as of the date of birth; or
- In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

To enroll under any of the above Special Enrollment circumstances, You must notify Your Employer and fill out the change in coverage section of the Enrollment Form. All information must be completed, the form signed and all required proof attached to the Enrollment Form. Or, You can contact the Plan Administrator at 1-888-670-8135. You must enroll within 31 days of Your loss of other coverage.

WHEN YOUR COVERAGE ENDS

Your Employee coverage ends on the earliest of the following dates:

a) The date the Plan is terminated;
b) The end of the month in which You terminate employment with Your Employer for any reason, including disability, death, retirement, lay-off, leave of absence or termination of employment;
c) The date You no longer meet eligibility requirements;
d) The day the Covered Person enters the military, navy or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any Calendar Year (Refer to Employees on Military Leave).
e) The end of the month during which any Plan ends, or is discontinued for a class of Employees to which You belong;
f) The last day of the period for which required payments have been made for You by Your Employer;

g) The last day of the period for which Your required contribution has been paid if the charge for the next period is not paid when due; or
h) The end of the month during which You or a covered Dependent become entitled to Medicare, unless You are actively at work.

See the Continuing Coverage Section for information about continuing health care coverage under COBRA or New Jersey Continuation for Yourself or a covered Dependent.

WHEN DEPENDENT COVERAGE ENDS

A covered Dependent's coverage ends on the earliest of the following dates:

a) date the Plan is terminated;
b) last day of the calendar month during which Your Dependent no longer meets eligibility requirements, such as reaching the age of 26;
c) date Your coverage ends;
d) last day of the calendar month during which You stop being a Member of a class of Employees eligible for coverage;
e) last day of the calendar month during which an applicable Plan of benefits ends;
f) last day of the period for which required payments have been made for You by Your Employer;
g) the last day of the period for which Your required contribution has been paid if the charge for the next period is not paid when due; or
h) last day of the calendar month during which Your Dependent reaches age 65, unless You are actively at work.

Your Dependent may be eligible to continue health care coverage beyond this period through COBRA or New Jersey Continuation (see Continuing Coverage Section for more information).

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff

You may remain eligible for a limited time if active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

- For disability leave only: the date the Employer ends the continuance.
- For leave of absence or layoff only: the date the Employer ends the continuance.

CONTINUATION OF COVERAGE

In addition to COBRA and Continuation Coverage (discussed later in this Plan in the section entitled Continuation Options), coverage may be continued in the following circumstances:

Continuation During Family and Medical Leave (FMLA)

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 and the regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under the Plan on the same Conditions as coverage would have been provided if the covered Employee had been continuously employed during the FMLA leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when coverage terminated. For example, Waiting Periods, if any, will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Re-employment Rights Act under the following circumstances (these rights apply only to Employees and their Dependents covered under the Plan before leaving for military service):

1) The maximum period of coverage for a covered Employee and the covered Employee's Dependent(s) under such an election shall be the lesser of:
   a) The eighteen (18) month period beginning on the date on which the Covered Person's absence begins; or
   b) The day after the date on which the Covered Person was required to apply for or return to a position or employment and fails to do so.

2) A previously Covered Person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3) A Plan Exclusion or Waiting Period, if any, may not be imposed in connection with the reinstatement of coverage upon the Covered Person's re-employment, if one would not have been imposed had coverage not been terminated because of the Covered

Person's military service. However, a Plan Exclusion or Waiting Period, if any, may be applied for coverage of any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed (military) service.

Continuity of Coverage

If a new Coverage Person was covered under Creditable Coverage prior to enrollment under the Plan and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Plan, the Plan will provide credit as follows. The Plan gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

The Plan will automatically provide You with a Certificate of Creditable Coverage detailing the beginning and ending dates of Your Plan coverage when You become eligible for COBRA or New Jersey Continuation and when Your coverage otherwise ends. You can request a Certificate of Coverage at any time for up to two (2) years after Your coverage under this Plan ends by contacting the Plan Administrator, at 1-888-670-8135.

OPEN ENROLLMENT

WHEN YOU CAN ENROLL

During Your Employer's Annual Open Enrollment Period (refer to section "Plan Administration Information" for more information), covered Employees and their covered Dependents will be able to change their current benefit elections based on which benefits and coverage levels are right for them. In addition, Employees and their Dependents who are Late Enrollees will also be able to enroll in the Plan during this period.

Benefit choices made during the open enrollment period will become effective based on Your Employer's Renewal Date (either January 1st, April 1st, July 1st, October 1st) and remain in effect until the next January 1st, April 1st, July 1st, October 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption, or leave of absence) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one Plan to another plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective based on Your Employer's Renewal Date (either January 1st, April 1st, July 1st, October 1st)

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present or comparable coverage if a Plan is eliminated.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS
WHAT'S COVERED

COVERED CHARGES FOR THE FOLLOWING

The following Covered Charges are reimbursed based on the Plan's Allowable Charges for all Plans unless specifically indicating otherwise and may be subject to the determination of Medical Necessity and Appropriateness, Plan Deductibles, Coinsurance, Copayment, or day/visit limitations. Please refer to the Schedule of Benefits for Your Plan for more detailed benefit information.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

ABORTION

Charges incurred for an elective abortion are considered covered services under this Plan.

ALLERGY TESTS/TREATMENT

Charges incurred for allergy tests and allergy treatments are considered covered services under this Plan.

AMBULANCE SERVICES

The Plan covers ground and/or air Ambulance services when Medically Necessary and Appropriate. Services require Pre-authorization in advance by the Plan (except in a medical Emergency). Pre-authorization for a non-Emergency Ambulance is required.

Medically Necessary and Appropriate charges for transporting You to:

- a local Hospital if needed care and treatment can be provided by a local Hospital,
- the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment (it must be in connection with an inpatient confinement), or
- another inpatient health care facility.

Ground Ambulance

Covered expenses include charges for transportation:

- To the first Hospital where treatment is given in a medical Emergency.
- From one Hospital to another Hospital in a medical Emergency when the first Hospital does not have the required services or facilities to treat Your Condition.
- From Hospital to home or to another facility when other means of transportation would be considered unsafe due to Your medical Condition.
- From home to Hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to Your medical Condition.
- When during a covered inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to safely and adequately transport You to or from inpatient or outpatient Medically Necessary and Appropriate treatment.

Air or Water Ambulance

Covered expenses include charges for transportation to a Hospital by air or water Ambulance when:

- Ground Ambulance transportation is not available; and
- Your Condition is unstable, and requires medical supervision and rapid transport; and
- In a medical Emergency, transportation from one Hospital to another Hospital; when the first Hospital does not have the required services or facilities to treat Your Condition and You need to be transported to another Hospital; and the two Conditions above are met.

Note: *The Plan does not pay for chartered air flights, or any other travel or communication expenses of patients, Physicians, Nurses or family Members inside or outside the United States*

AMBULATORY SURGICAL CENTER CHARGES

The Plan covers Ambulatory Surgical Center charges in connection with covered Surgery. Services require Pre-authorization in advance by the Plan when required. Out-of-Network facility charges for outpatient ambulatory Surgery is limited to a $1,000 maximum allowable charge per Surgery, if Your Plan has an out-of-network benefit.

ANESTHETICS AND OTHER SERVICES AND SUPPLIES

The following anesthetic and other services and supplies are covered:

- anesthetics and their administration, hemodialysis, casts, splints, prosthetics, surgical dressings and the initial fitting and purchase of braces, trusses and crutches. Replacements or repairs are not covered;

- blood, blood products, blood transfusions and the cost of testing and processing blood, except for blood that has been donated or replaced on behalf of the Covered Person. Blood storage is not covered by the Plan;
- Medically Necessary and Appropriate supplies, other than those excluded by the Plan; and

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a Birthing Center provided the Physician in charge is acting within the scope of his license and the Birthing Center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a covered expense if the state in which such service is performed has legally recognized midwife delivery. Coverage is provided for prenatal care, delivery, and postpartum care within 48 hours after a vaginal delivery and 96 hours after a cesarean delivery

CARDIAC REHABILITATION

Cardiac rehabilitation as deemed Medically Necessary and Appropriate provided services are rendered

- under the supervision of a Physician;
- in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
- initiated within 12 weeks after other treatment for the medical Condition ends; and
- in a Medical Care Facility as defined by this Plan.

CHIROPRACTIC SERVICES/SPINAL MANIPULATION

Chiropractic services/Spinal Manipulation by a licensed M.D., D.O. or D.C. for covered Members age 18 and older only. All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

COVERED NEWBORN CHILD

The following charges are covered in association with a newborn Child under the mother's admission for the following services:

- routine Nursery care while the Child is in the Hospital;
- charges for routine examinations and tests;
- charges for routine procedures, such as circumcision.

Note: Newborn Children must be enrolled in the Plan within 31 days in order to be covered by the Plan. Please contact Your Employer or the Plan Administrator at (888) 670-8135.

DENTAL SERVICES

Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of impacted teeth.
- Surgical TMJ only.
- Hospital and general anesthesia services provided to a severely disabled or Child five (5) or under for dental services.
- A medical Condition eligible under this Plan which requires Hospital and general anesthesia for dental services rendered by a Dentist.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures, crowns and/or routine dental care with the exception of dental bridge work when the services are required for the management of a congenital anomaly.

DIABETIC SERVICES, SUPPLIES AND TRAINING

Charges for the treatment of diabetes must be recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse in order to be considered as covered charges under this Plan. The following equipment and supplies are covered charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

- blood glucose monitors;
- blood glucose monitors for the legally blind;
- cartridges for the legally blind;
- test strips for glucose monitors;
- visual reading and urine testing strips;
- insulin;
- insulin pumps and necessary accessories;
- insulin infusion devices;
- injection aids;

- lancets;
- needles and syringes; and
- oral agents for controlling blood sugar levels.

The following services and training are eligible charges:

- routine diabetes foot care;
- self-management education which is provided by a health care professional recognized as a Certified Diabetes Educator, a Registered Dietician or a state licensed Pharmacist; and
- nutritional counseling. Limited to 2 visits per Condition.

Note: Benefits for self-management and nutritional counseling and education will be provided for any of the following three (3) reasons:

- ✓ when diabetes is diagnosed;
- ✓ when a change in self-management occurs through a significant change in a Covered Person's Conditions or symptoms; or
- ✓ re-education is required.

DIALYSIS CENTER CHARGES

Dialysis center charges for covered dialysis services are covered through coordination of benefits with Medicare and this Plan. These services and supplies must be pre-authorized by the Plan.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

The Plan covers Medically Necessary and Appropriate charges for the rental of Durable Medical Equipment, including oxygen, needed for therapeutic use, when pre-authorized by the Plan up to the maximum shown in the Schedule of Benefits. At the option of the Plan, the purchase of such items may be covered when it is less costly and more practical than rental.

The Plan does not pay for:

- Durable Medical Equipment supplied by an out of Network Provider;
- any purchases without advance written approval from the Plan;
- replacements or repairs;
- the rental or purchase of items such as, but not limited to, air Conditioners, exercise equipment, saunas or air humidifiers that do not fully meet the definition of Durable Medical Equipment; or
- adjustable and/or supportive chairs or orthopedic mattresses.

The Plan also covers the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices that take the place of a natural part of a covered patient's body, or are needed due to a functional birth defect in a covered Dependent Child.

The Plan does not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs or dental prosthetics or devices. However, the Plan will cover these replacements if there is a sufficient change in a Covered Person's physical Condition to make the original devices no longer functional.

The Plan covers dental prosthetics or devices only when resulting from accidental Injury to sound, natural teeth within six months of an accidental Injury. Orthotic devices must correct a defect of body form or function. Only the basic device is covered, and any Medically Necessary and Appropriate special features require Prior-authorization.

The Plan covers hearing aids for Children under the age of 16. Coverage is provided when a licensed Physician or audiologist prescribes or recommends a hearing aid; and the Plan determines that it is Medically Necessary and Appropriate. Benefits provided are up to a maximum of $1,000
per hearing aid for each hearing-impaired ear, every 24 months. In addition the Plan covers Medically Necessary and Appropriate expenses incurred in the purchase of a hearing aid such as examinations, hearing tests, fittings, dispensing fees, modifications and repairs, ear molds, and
headbands for bone-anchored hearing implants. For hearing aids costing more than $1,000, the benefit is the allowable cost of the hearing aid minus the application of any copay, Deductible, and coinsurance. The Plan will not pay more than $1,000 for each hearing impaired ear in any 24 month period.

Definition You Need to Know
Durable Medical Equipment – equipment that is designed to withstand repeated use, used primarily for a medical purpose, generally not useful to a Covered Person in the absence of an illness or Injury and suitable for use in the home. Examples of Durable Medical Equipment include apnea monitors, breathing equipment, Hospital-type beds, walkers and wheelchairs.

EMERGENCY CARE

Do not delay getting medical care in the event of an Emergency. If a Hospital admission and/or Surgery is required due to a life-threatening Illness or Injury, get the immediate care You need. Then, You or Your Physician must call the Plan at 1-888-670-8135 within 48 hours, or as soon as possible after the admission occurs. In addition, You or Your doctor must request a continued stay review for any Emergency admission.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

Definition You Need to Know

Emergency — **Emergency** means a medical Condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbance and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate attention to result in: placing the health of the individual (or with respect to a pregnant woman, that health of the woman or her unborn Child) in serious jeopardy: serious impairment to bodily functions; or serious dysfunction of a bodily organ to part. With respect to a pregnant woman who is having contractions, an Emergency exist where: where is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn Child.

Conditions that require immediate treatment include, but are not limited to, the following:

- heart attacks
- convulsions
- bone fractures
- poisoning,
- strokes,
- serious burns,
- wounds requiring sutures,
- loss of consciousness.

In addition, the service provided must be a covered service or supply, and not one that is normally treated on a non-Emergency basis.

Coverage if You Are Out of Town

If You require medical attention while You are traveling or Your covered Dependent Child requires care while away at school, the Plan will pay benefits as follows if an Out-of-Network Provider is utilized:

Emergency care will be reimbursed at the network level. Emergency care includes Conditions that require immediate treatment, such as bone fractures, wounds requiring sutures, poisoning and loss of consciousness.

Urgent Care will be reimbursed at the out-of-network level, if You have out-of-network benefits. Urgent Care includes non-Emergency Conditions for which treatment cannot reasonably be postponed, such as minor cuts, sprains or strep throat. You should always try to find a Participating Provider for these services to lessen Your out of pocket expenses.

Elective care will be reimbursed at the out-of-network level, if You have out-of-network benefits. You should always try to find a Participating Provider for these services to lessen Your out of pocket expenses.

Care Not Available Within the Network

The Plan has a special feature for those rare instances in which You need care that is not available within the Network. This feature permits You to get specialized care for certain procedures from out-of-Network Providers and receive the network level of benefits. Any Physician charges provided during an inpatient/outpatient stay must be Medically Necessary and Appropriate as determined by the Plan.

You must obtain Pre-authorization from the Plan prior to receiving services and treatment in order to receive the network level of benefits through this special feature.

HOME HEALTH CARE

Home Health Care Services may include alternatives to Hospitalization, such as a participating home health agency, as long as services and treatment are pre-authorized by the Plan and Medically Necessary and Appropriate.

In general, the following services are covered but limited to 60 visits every Benefit Year, not to exceed 4 hours per visit:

- skilled nursing care (provided by or under the supervision of a registered professional Nurse);
- services of a home health aide, under the supervision of a registered professional Nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the home health services is skilled in nature;
- medical social services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other home health services, if the Plan pre-authorizes these services;
- occupational and/or physical therapy;
- nutrition services; and
- medical appliances and equipment, Drugs and medications, laboratory services and special meals.

The following Conditions also apply:

- Your Physician must certify that home health care is needed in place of inpatient care in a recognized facility. The services and supplies must be ordered by Your Physician, included in the Home Health Care Plan, and provided by — or coordinated by — a Home Health Care Agency according to the written Home Health Care Plan.
- The services and supplies must be provided by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
- The Home Health Care Plan must be provided in writing by Your Physician within 14 days after home health care starts. It must be reviewed by Your Physician at least once every 60 days.
- Each visit by a home health aide, Nurse or other recognized provider whose services are authorized under the Home Health Care Plan can last up to four hours.

The Plan does not cover:

- ✓ services provided by an out of Network Provider
- ✓ services provided to family Members, other than the patient, or
- ✓ services and supplies not included in the Home Health Care Plan, and
- ✓ charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, unless it is authorized as part of a Home Health Care Plan, coordinated by a Home Health Care Agency and covered under home health care charges.

Note: The Plan is not required to provide home health benefits if it determines that the treatment setting is not appropriate, or when a more cost-effective setting in which to provide Medically Necessary and Appropriate care is available.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

HOSPICE CARE CHARGES

Charges made by a hospice for *palliative and supportive care* provided to a *terminally ill* or *terminally injured* Member under a hospice care program are covered. *Palliative and supportive care* means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the terminal Illness or terminal Injury. *Terminally ill* or *terminally injured* means that a Physician has certified, in writing, that the Covered Person's life expectancy is six months or less. Hospice care must be pre-authorized by the Plan. Under a hospice care program, any eligible services and supplies, including prescription Drugs, are covered by the Plan. Services and supplies may be provided on an inpatient or outpatient basis.

The services and supplies must be:

- needed for palliative and supportive care;
- ordered by the Covered Person's Physician;
- included in the Hospice Care Plan; and
- provided by, or coordinated by, a hospice.

The Plan does not pay for:

- services and supplies provided by volunteers or others who do not regularly charge for their services;
- funeral services and arrangements;
- legal or financial counseling or services;
- Bereavement Counseling; or
- treatment not included in the Hospice Care Plan.

Note: *Hospice care must be provided according to a written Hospice Care Plan. This is a coordinated program with an interdisciplinary team designed to meet the special needs of the terminally ill or terminally injured Member. It must be set up and reviewed periodically by Your Physician.*

INFERTILITY SERVICES

The Plan covers only the work-up to determine the diagnosis of Infertility. There are no benefits for Infertility related services as shown in the Schedule of Benefits, unless Your Employer has purchased the Infertility Rider. 50+ size groups may be able to purchase the Infertility Rider. To determine if You have coverage for Infertility Services and the extent of that coverage, please contact the Plan Administrator.

INHERITED METABOLIC DISEASE

The Plan covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products as determined to be Medically Necessary and Appropriate by the Covered Person's Physician.

INPATIENT HOSPITAL COVERED SERVICES

The Plan covers the following inpatient services when pre-authorized by the Plan.

(1) Semi-private room and board accommodations, see Schedule of Benefits for any daily limits that may apply;
(2) Hospital charges related to labor and delivery, in accordance with the Newborns' and Mothers' Health Protection Act:
- a minimum of 48 hours of inpatient care in a Hospital following a vaginal delivery, and

a minimum of 96 hours of inpatient care in a Hospital following a cesarean section, provided that the attending Physician determines that inpatient care is Medically Necessary and Appropriate, or the mother requests the inpatient care, but

- an exception can be made to the 48-hour and 96-hour rules if the attending provider decides, in consultation with the mother, to discharge the mother or newborn earlier;

(3) Private accommodations only when Medically Necessary and Appropriate and Pre-authorized. Otherwise, You are liable to the facility for the difference in payment covered by the Plan and the private-room rate;
(4) Pre-admission testing, provided the tests are performed on an outpatient basis within seven days of the planned admission and Surgery.
(5) routine nursing care;
(6) use of intensive or special care facilities- daily limits apply;
(7) X-ray examinations including CAT scans, but not dental X-rays unless related to covered services;
(8) use of operating room and related facilities;
(9) magnetic resonance imaging (MRI);
(10) Drugs, medications and biologicals;
(11) cardiography/encephalography;
(12) laboratory testing and services;
(13) pre- and post-operative care;
(14) special tests;
(15) nuclear medicine;
(16) Therapy Services;
(17) oxygen and oxygen therapy;
(18) anesthesia and anesthesia services;
(19) blood processing and administration;
(20) intravenous injections and solutions; and
(21) Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

LABORATORY TESTS AND X-RAYS

X-rays and laboratory tests that are Medically Necessary and Appropriate to treat an Illness or Injury are covered by the Plan. However, the Plan does not pay for X-rays and tests performed as part of a routine physical checkup, unless specifically listed in the Wellness Schedule. Plan covers costs for services including Magnetic Resonance Imaging (MRI) and CAT scans, but not dental x-rays unless related to covered services.

MAMMOGRAMS — ROUTINE SCREENING

The Plan covers network charges for:

- Baseline mammography between 35 and 39 years of age
- Annual Mammography and cytologic screening (annual exams age 40 and over)
- More frequent Mammography if recommended by Your Physician

MENTAL HEALTH AND SUBSTANCE ABUSE

The Plan complies to the federal law known as the Mental Health Parity and Addiction Equity Act of 2008, which requires that benefits provided for mental health and Substance Abuse disorders are consistent with benefits provided under the plan's general medical/surgical coverage.

The Plan covers the following mental health and Substance Abuse services. To receive the network level of benefits, services must be provided by a participating Physician at the provider's office or at a participating Substance Abuse center.

Mental and Nervous Conditions

- Outpatient Services. Benefits include diagnosis, medical, psychiatric and psychological treatment for Mental and Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available.
- Inpatient. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) Physician, psychologist, Nurse and trained staff services; (3) diagnostic X-ray; (4) psychiatric, psychological and medical laboratory testing; (5) Drugs, medicines, equipment use and supplies.
- Partial Hospitalization Services. Members are eligible for a partial Hospitalization treatment program.
- Court ordered admissions are not covered.

Note: You must receive Pre-certification for Inpatient Mental and Nervous admissions.

Substance Abuse

- Outpatient Services. Benefits include diagnosis, medical, psychiatric and psychological treatment for the abuse or addiction to Drugs or alcohol. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are entitled to unlimited Outpatient Care benefits for detoxification.

- Inpatient. Members are entitled to receive inpatient rehabilitation for the treatment of medical Conditions resulting from Substance Abuse and Referral services for Substance Abuse or addiction. The following services shall be covered under inpatient rehabilitation: (1) lodging and dietary services; (2) Physician, psychologist, Nurse, certified addictions counselor and trained staff services; (3) diagnostic X-ray; (4) psychiatric, psychological and medical laboratory testing; (5) Drugs, medicines, equipment use and supplies.
- Partial Hospitalization Treatment. Members are eligible for a partial Hospitalization treatment program for alcohol or Substance Abuse or addiction.
- Special Note For Chemical Dependency Admissions. Court ordered chemical dependency admissions are not covered.

All Treatment for a Covered Person's care is subject to the benefits shown in the Schedule of Benefits.

NUTRITIONAL COUNSELING

The Plan covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed and provided by a Physician, Physician assistant, Nurse, or registered dietician. Limited to 2 visits per Condition.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a covered expense. Orthopedic shoes or corrective shoes are covered. Replacement will be covered only when a physiological change in the patient's Condition necessitates replacement.

OSTOMY SUPPLIES

The following equipment and supplies are covered charges when recommended or prescribed by a Physician, Nurse Practitioner or Clinical Nurse:

- Pouch	- Adhesives/Removers	- Dressings	- Appliance Cleaners
- Ostomy Belts	- Skin Barriers/Wafers	- Irrigators	- Closures

OUTPATIENT HOSPITAL SERVICES

The Plan covers outpatient Hospital services, including services provided by a Hospital outpatient clinic. Services require Pre-authorization in advance by the Plan when required.

PHYSICIAN SERVICES

Covered expenses shall include:

- Charges made by a Physician during a visit to treat Illness or Injury. The visit may be at the Physician's office, in Your home, or in a Hospital or other facility during Your stay or in an outpatient facility
- Surgical treatment.
- Surgical assistance provided by a Physician if it is determined that the Condition of the Covered Person or the type of surgical procedure requires such assistance.
- Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
- Consultations requested by the attending Physician during a Hospital confinement. Consultations do not include staff consultations that are required by a Hospital's rules and regulations.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
- Radiologist or pathologist services for diagnosis or treatment, including Radiation Therapy and Chemotherapy.
- Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

PREGNANCY BENEFITS

You'll need to obtain one Pre-authorization for the Pregnancy. You or Your doctor must call 1-888-616-4224 and request a pre-Hospital review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

Group Health Plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with Childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PRESCRIPTIONS

Prescription Drugs (when provided as part of a covered inpatient admission). See Prescription Drug Section of this document for more information on Your Prescription Drug Card Program.

PREVENTIVE CARE

Preventive Services Covered under the Affordable Care Act must be covered 100% by a Network Provider. For more information visit http://www.healthcare.gov.

Preventive Services for Children:

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism** screening for Children at 18 and 24 months
3. **Behavioral** assessments for Children of all ages (0-17 years)
4. **Blood Pressure** screening for Children (0-17 years)
5. **Cervical Dysplasia** screening for sexually active females
6. **Congenital Hypothyroidism** screening for newborns
7. **Depression** screening for adolescents
8. **Developmental** screening for Children under age 3, and surveillance throughout Childhood
9. **Dyslipidemia** screening for Children at higher risk of lipid disorders (0-17 years)
10. **Fluoride Chemoprevention** supplements for Children without fluoride in their water source
11. **Gonorrhea** preventive medication for the eyes of all newborns
12. **Hearing** screening for all newborns
13. **Height, Weight and Body Mass Index** measurements for Children (0-17 years).
14. **Hematocrit or Hemoglobin** screening for Children
15. **Hemoglobinopathies** or sickle cell screening for newborns
16. **Human Immunodeficiency Virus (HIV)** screening for adolescents at higher risk
17. **Immunization** vaccines for Children from birth to age 18 —doses, recommended ages, and recommended populations vary
18. **Iron** supplements for Children ages 6 to 12 months at risk for anemia
19. **Lead** screening for Children at risk of exposure
20. **Medical History** for all Children throughout development (0-17 years).
21. **Obesity** screening and counseling
22. **Oral Health** risk assessment for Young Children (0-10 years)
23. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
24. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
25. **Tuberculin** testing for Children at higher risk of tuberculosis (0-17 years).
26. **Vision** screening for all Children

Preventive Services for Adults:

1. **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
2. **Alcohol Misuse** screening and counseling
3. **Aspirin** use for men and women of certain ages
4. **Blood Pressure** screening for all adults
5. **Cholesterol** screening for adults of certain ages or at higher risk
6. **Colorectal Cancer** screening for adults over 50
7. **Depression** screening for adults
8. **Type 2 Diabetes** screening for adults with high blood pressure
9. **Diet** counseling for adults at higher risk for chronic disease
10. **Human Immunodeficiency Virus (HIV)** screening for all adults at higher risk
11. **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary
12. **Obesity** screening and counseling for all adults
13. **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
14. **Tobacco Use** screening for all adults and cessation interventions for tobacco users
15. **Syphilis** screening for all adults at higher risk

Preventive Services for Women (Including Pregnant Women)

1. **Anemia** screening on a routine basis for pregnant women
2. **Bacteriuria** urinary tract or other infection screening for pregnant women
3. **BRCA** counseling about genetic testing for women at higher risk
4. **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
5. **Breast Cancer Chemoprevention** counseling for women at higher risk
6. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. **Cervical Cancer** screening for sexually active women
8. **Chlamydia Infection** screening for Younger women and other women at higher risk
9. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient Drugs
10. **Domestic and interpersonal violence** screening and counseling for all women
11. **Folic Acid** supplements for women who may become pregnant

12. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. **Gonorrhea** screening for all women at higher risk
14. **Hepatitis B** screening for pregnant women at their first prenatal visit
15. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
16. **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. **Osteoporosis** screening for women over age 60 depending on risk factors
18. **Rhesus Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
19. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. **Sexually Transmitted Infections (STI)** counseling for sexually active women*
21. **Syphilis** screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services.

PRIVATE DUTY NURSING CARE

Private duty nursing care by a licensed Nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

- **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and Appropriate and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a covered expense.

A charge for the purchase of prosthesis is considered incurred on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a Covered Person's coverage under this Plan is not covered.

Repair or replacement of a prosthesis, which is, Medically Necessary and Appropriate due a physiological change in the patient's Condition will be considered a covered expense.

RECONSTRUCTIVE / COSMETIC SURGERY

Cosmetic Surgery or reconstructive Surgery shall only be a covered expense in the event:

- A Covered Person receives an Injury because of an accident and as a result requires Surgery. Cosmetic or reconstructive Surgery and treatment must be for the purpose of restoring the Covered Person to his normal function immediately prior to the accident; or,
- It is required to correct a congenital anomaly, for example, a birth defect for a Child.

Mastectomy

Correction of abnormal congenital Conditions and reconstructive mammoplasties will be considered covered charges. This mammoplasty coverage will include reimbursement for:

- reconstruction of the breast on which a mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas and two (2) post mastectomy bras per year, in a manner determined in consultation with Your Physician.

ROUTINE PREVENTIVE CARE

Covered charges under Medical Benefits are payable for routine preventive Care as described in the **Schedule of Benefits.**

- **Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.
- **Charges for Routine Well Child Care.** Routine well Child care is routine care by a Physician that is not for an Injury or Sickness.

Flu vaccinations are to be covered at 100% not subject to Deductible or co-pay. There is no benefit, however, if service is provided by an out-of-Network Provider.

Routine care is not covered if solely for the purpose of travel, attendance at summer camp, or as a requirement for Your employment or school.

SKILLED NURSING CARE, EXTENDED CARE OR REHABILITATION SERVICES

The Plan covers the following for Skilled Nursing, Extended Care and Rehabilitation Facilities:

- Medically Necessary and Appropriate charges provided in a skilled nursing, Extended Care Center or rehabilitation center. The Plan does not cover charges above Plan limitations.

- all other Medically Necessary and Appropriate services and supplies provided during a confinement. However, the confinement must meet the following criteria:

  - the patient is confined as a bed patient in the facility;
  - the confinement starts within fourteen (14) days of discharge from a Hospital confinement or directly from home;
  - the Attending Physician certifies that the confinement is needed for further care of the Condition that caused the Hospital confinement; and
  - the Attending Physician completes a treatment Plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the skilled facility.

The Plan provides combined coverage for skilled care, extended care and rehabilitation services for a combined sixty (60) days for each Condition per Plan Benefit Year. The Plan does not cover charges for any additional days.

Charges which are in excess of sixty (60) days per Condition maximum per Plan Benefit Year will not be considered as covered charges.

Definitions You Need to Know
Hospice — a provider that offers palliative and supportive care for terminally ill or terminally injured people under a hospice care program.
Rehabilitation Facility — a facility that mainly provides therapeutic and restorative services to ill or injured people.
Skilled Nursing Facility — a facility that mainly provides full-time skilled nursing care for ill or injured people who do not need to be in a Hospital. In some places, a skilled nursing center may be called an "Extended Care Center."

SLEEP DISORDERS

Covered expenses shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

SPINAL MANIPULATION/CHIROPRACTIC SERVICES

Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C. for covered Members age 18 and older only.

All Treatment for a Covered Person's care is subject to the Benefit Payment maximums/limitations shown in the Schedule of Benefits.

SURGICAL/MEDICAL SERVICES. The professional services of a Physician for surgical or medical services. Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Plan Allowable Charge that is allowed for the primary procedures; 50% of the Plan Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Plan Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Plan Allowable Charge allowed for that procedure; and
- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the Plan's Allowable Charges

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of Morbid Obesity for Covered Persons with health problems that are aggravated by or related to the Morbid Obesity. All services must be pre-certified.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) or Myofascial Pain Syndrome shall be a covered expense, but shall not include orthodontia or prosthetic devices prescribed by a Physician or Dentist or treatment to alter vertical dimension or to restore abraded dentition. This limitation shall apply whether treatment is provided by a Hospital, Physician, Dentist, physical therapist or oral surgeon.

THERAPY SERVICES

The following are covered services or supplies ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

1. Autism - Medically Necessary and Appropriate physical therapy, Occupational Therapy and Speech Therapy for the **treatment of autism or another developmental disability**. Additionally, expenses incurred for Medically Necessary and Appropriate behavioral interventions based on the principles of **applied behavioral analysis (ABA)** and related to structured behavioral programs for the treatment of autism in Dependents under 21 years of age are covered.

Benefits are provided for:

- Children who are being or who will be screened and/or diagnosed for autism or another developmental disability (as defined below); and
- Children who have a primary diagnosis of autism or another developmental disability.

Coverage includes:

a) Expenses incurred in screening and diagnosing autism or another developmental disability;
b) When the Dependent's primary diagnosis is autism or another developmental disability, expenses incurred for Medically Necessary and Appropriate occupational therapy, Physical Therapy and Speech Therapy, when prescribed as part of a treatment Plan;
c) Coverage of the above therapies will be covered even if the treatment is not restorative;
d) Coverage is limited to Dependents under the age of 21;
e) When the primary diagnosis is autism, expenses incurred for Medically Necessary and Appropriate behavioral interventions based on the principles of applied behavioral analysis and related to structured behavioral programs, when prescribed as part of a treatment Plan;
f) Benefits listed in item e) above will not be denied on the basis that the treatment is not restorative;
g) Benefits listed in item e) above shall be provided to the same extent as those for any other medical Condition covered by the Plan, but shall not be subject to the limits on the number of visits that a Covered Person may make to a provider of behavioral interventions;
h) The maximum benefit amount for any Covered Person in any Calendar Year through 2012 shall be $37,080. Beginning in 2012, the maximum benefit amount will be increased based on the Consumer Price Index.

For such coverage to be in effect, it is necessary for the Covered Person to obtain a treatment Plan from the Dependent's Physician and to submit that Plan to the Plan Administrator. Failure to submit an appropriate treatment Plan will delay coverage. The treatment Plan shall include all elements necessary for the Plan to appropriately provide benefits, including but not limited to:

- A diagnosis;
- Proposed treatment by type, frequency and duration of service;
- The anticipated outcomes, stated as goals
- The frequency by which the treatment Plan will be updated. The Plan Administrator may only request an updated treatment Plan every six months from the treating Physician in order for it to review Medical Necessity and Appropriateness, unless the Plan Administrator and the treating Physician agree that a more frequent review is necessary due to emerging clinical circumstances; and
- The treating Physician's signature.

The term "developmental disability" means a severe, chronic disability of a person which:

- is attributable to a mental or physical impairment or combination of mental or physical impairments;
- is manifested before age 22;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity, i.e., self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economical self-sufficiency; and
- reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are not of a life-long or extended duration and are individually Planned and coordinated. Developmental disability includes but is not limited to: severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

2. **Cardiac Rehabilitation Therapy** - program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.
3. **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents. The materials and services of technicians are included.
4. **Cognitive Rehabilitation Therapy** - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic processes. Therapy must be by a licensed psychologist. Therapy must be In accordance with a Physician's exact orders as to type, frequency, and duration to improve cognitive skills.
5. **Dialysis Treatment** - the treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
6. **Infusion Therapy** - the administration of antibiotic, nutrients or other therapeutic agents by direct infusion.
7. **Occupational Therapy** - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Therapy must be by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
8. **Physical Therapy** - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb. Treatment is covered by a licensed physical therapist. The therapy must be in accordance with a Physician's exact orders as to type, frequency and duration and to improve a body function.

9. **Radiation Therapy** - the treatment of disease by X-ray, radium, cobalt, or high-energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy. The materials and services of technicians are included.
10. **Speech Therapy** - treatment by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) Surgery for correction of a congenital Condition of the oral cavity, throat or nasal complex (other than a frenectomy of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

All Treatment for a Covered Person's care for Therapy Services is subject to the Benefit Payment maximums/ limitations shown in the Schedule of Benefits.

TRANSPLANT BENEFITS

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational" and performed by an institution approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists. Pre-certification is required.

The Plan covers Medically Necessary and Appropriate, pre-certified services and supplies for the following types of organ and tissue transplants:

(1) cornea, kidney, lung, liver, heart and pancreas;
(2) allogeneic bone marrow;
(3) autologous bone marrow transplant and associated dose-intensive Chemotherapy; and
(4) peripheral blood stem cell transplants and associated dose-intensive Chemotherapy.

Charges for the care and treatment due to an organ or tissue transplant are covered, subject to the following limits:

(1) The transplant must be performed to replace an organ or tissue.

(2) Charges for obtaining donor organs are covered charges under this Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her Plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

   a. evaluating the organ;

   b. removing the organ from the donor; and

   c. transportation and storage costs directly related to the donation of the organ and billed by the Hospital.

(3) If the organ donor is a Covered Person and the recipient is not, then this Plan will cover donor organ charges for:

   a. evaluating the organ, and

   b. removing the organ from the donor.

This Plan will always pay benefits secondary to any other benefit plan.

VISION CARE BENEFITS

The Plan network includes vision care providers. You will receive coverage only if You visit a participating Network Provider for care.
The Plan covers the following services and supplies when provided by a participating vision care provider at his or her office:

- complete vision examination with refraction, limited to one Routine examination per Benefit Year (except for Plan F).
- Initial **contact lenses** or glasses required following cataract Surgery.

WELL NEWBORN CARE

The Plan shall cover well newborn care as part of the mother's claim while the mother is confined for delivery. Such care shall include, but is not limited to:

- Physician services
- Hospital services
- Circumcision

WIGS

The Plan will allow for the coverage of a wig or hairpiece prescribed by a Physician as a prosthetic for hair loss due to Injury, disease, or treatment of a disease.
Examples of covered Illnesses are:

- Burns – 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia
- Lupus
- Alopecia areata with near complete or complete cranial hair loss
- Alopecia totalis
- Alopecia universalis
- Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatment resulting in near complete or complete cranial hair loss

- Chemotherapy
- Radiation therapy

WILM'S TUMOR

The Plan covers charges incurred for the treatment of Wilm's Tumor, even if it is deemed Experimental or ilvestigational. Treatment can include, but is not limited to, autologous bone marrow transplants when standard Chemotherapy treatment is unsuccessful.

WOMEN'S PREVENTIVE CARE

Well-woman visits such as annual health care visits, preconception and prenatal care will be covered under the HHS Guidelines. When appropriate these well-women visits will include other preventive services listed in the guidelines, Section 2713 of the PHSA (such as some routine immunizations). In addition to the above mentioned, the following services are also covered:

- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies and counseling
- Domestic violence screening

REFER TO ATTACHED SCHEDULE OF BENEFITS FOR DETAILED PLAN DESIGN COMPONENTS

YOUR BENEFITS

Verification of Eligibility (888) 670-8135

You should call this number to verify a Covered Person's eligibility for Plan benefits **before** the charge is incurred.

REFER TO ATTACHED SCHEDULE OF BENEFITS FOR THE PLAN THAT YOU ARE ENROLLED IN.

WHAT ARE THE BENEFITS?

All benefits described in this Plan Document and Summary Plan Description and **attached Schedule of Benefits** are subject to the exclusions and limitations described more fully herein including, but not limited to, the Claims Administrator's determination that care is: (i) not Medically Necessary and Appropriate; (ii) not based on the QualCare Plan Allowable Charges; and (iii) Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

It is the Covered Person's choice as to which Provider to use (Some services are not covered when provided by an Out-of-Network Provider. Review the **attached Schedule of Benefits** and remainder of this document carefully.). If You are covered under a Network Only Plan, You have no out-of-network benefit. You may only receive coverage for services provided by In-Network Providers.

If You or a covered Dependent need covered services recommended by Your Physician that are not available within the Network, Utilization Review/Claims Administrator may, at its Discretion, determine the Medical Necessity and Appropriateness, and approve the use of an Out-of-Network Provider. When approved through Utilization Review Services and/or the Claims Administrator, benefits for use of these providers will be payable at the same level as those of Network Providers, had those services been available. Reimbursement will be considered based on billed charges.

PLAN BENEFITS - HOW THE PLAN WORKS

IMPORTANT

Please read Your Schedule of Benefits carefully. Make sure You are reviewing the benefits for the Plan that You and Your Dependents are enrolled in. If You have any questions regarding which Plan You are enrolled in, please contact the Plan at (888) 670-8135.

Definitions You Need to Know

Copayments or Copay. A copayment is a small amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment. Refer to the Schedule of Benefits for copayment amounts.

Deductibles. A Deductible is an amount of money that is paid once a Calendar Year per Covered Person. It must be paid before any money is paid by this Plan for any covered services (with a few exceptions). The Deductible is based on the benefit year and each January 1st, a new Deductible amount is required. The Deductible is in addition to any Hospital admission Deductible or Hospital outpatient visit Deductible (if and when applicable) as shown in the Schedule of Benefits.

You can satisfy the Family "Deductible" or the Family "Maximum Out-of-pocket" by meeting the individual amount for any one (1) covered family Member and then any combination of family Members may satisfy the remaining amount. No more than the individual amount will be credited to the Family amount for any one Covered Person and no Covered Person will be required to meet more than the individual amount each Benefit Year. Refer to the Schedule of Benefits for Individual and Family amounts.

Definitions You Need to Know

Maximum Out-of-Pocket. The Plan will pay the percentage of covered charges designated in the Schedule of Benefits until the out-of-pocket maximum(s) are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.

Charges for the following do not apply to the 100% benefit limit and are never paid at 100%:

- ✓ *Deductibles and all Copayments (unless specified otherwise for High Deductible HSA Compatible Plans).*
- ✓ *Cost containment penalties (failure to pre-certify services).*
- ✓ *Any charges considered as non-covered (e.g., any amounts above the Plan's Allowable Charges, charges for non-covered services)*

Routine Wellness Schedule- All Ages

ROUTINE WELLNESS SCHEDULE - ALL AGES

The following wellness schedule applies to all plans offered by the Affiliated Physician & Employers Health Plan Trust.

All Wellness Services are not covered if using an Out-of-Network Provider.

Childhood, Adolescent, and Young Adult Health Supervision Visits are covered by the Plan at the ages listed in Table 1.

Table 1. Ages at Which Childhood Health Supervision Visits Are Covered

Newborn	9 months
First week of life	12 months
1 month	15 months
2 months	18 months
4 months	2 years
6 months	2 ½ years
Annually from age 3 years through age 21 years	

Vaccines given to Children, adolescents, and Young adults through age 21, alone or in combination, are covered under this Plan within the designated age ranges and up to the specified number of doses as shown in Table 2:

Table 2. Covered Childhood Vaccinations

Updated regularly by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Vaccine	Doses in Series	Primary Age Range	Catch Up Range
Hepatitis B	3	Birth – 18 months	19 months – 21 years
Rotavirus	3	6 weeks – 32 weeks	None
DtaP*	5	2 months – 6 months	4 – 6 years
Tdap	1	10 years	Through age 21 years And postpartum
Haemophius influenzae b (Hib)*	4	2 months – 15 months	18 months – 6 years
Pneumococcal conjugate	4	2 months – 6 years	None
Pneumococcal polysaccharide	1	None	7 – 21 years if Medically Necessary and Appropriate
Inactivated Polio*	4	2 months – 6 years	Through age 21 years
Influenza	Annual	6 months – 21 years	Not applicable
Measles**	2	12 – 15 months	Through age 21 years
Mumps**	2	12 – 15 months	Through age 21 years
Rubella**	2	12 – 15 months	Through age 21 years
Varicella**	2	12 months – 6 years	Through age 21 years
Hepatitis A	2	12 – 18 months	Through age 21 years
Meningococcal	1 – 2	2 years	Through age 21 years
Human papillomavirus (HPV) - *(Cervical cancer vaccine)*	3	9 – 12 years	Through age 21 years

*Vaccines marked with single asterisk (*) are covered whether given singly or in combination with each other.
**Vaccines marked with double asterisk (**) are covered whether given singly or in combination with each other.

Tests or interventions during Childhood Health Supervision Visits covered separately by the Plan, visits are shown in Table 3.

Table 3. Tests or Interventions Covered in Addition to Childhood Health Supervision Visit

Age/Age Range	Test or Intervention
Newborn – 2 months	Vision Screen (Visual Evoked Potential) Hearing Screen (Auditory Evoked Potential)
Newborn – 2 months	Hemoglobin and Metabolic Screening (PKU, Hypothyroidism)
9 months, 18 months, 30 months	Autism Screening
12 months (earlier and more often if indicated by history)	Hemoglobin
12 months and 24 months	Lead screening
At any visit after 1 month, if indicated by history	Tuberculin Skin Test
3 – 5 years	Baseline Urinalysis
11 – 18 years	One dipstick urinalysis annually for male and female adolescents who are sexually active
18 – 21 years (earlier if indicated by history and/or physical examination)	Dyslipidemia Screening (cholesterol, lipid panel)
11 years – 21 years (if indicated by history and/or physical examination)	Sexually Transmitted Infection Screening (e.g., Cervical or Urethral Culture)
11 years – 21 years (if indicated by history and/or physical examination)	Cervical Dysplasia Screening (e.g. Pap Smear)

Adult wellness evaluations and interventions covered under this Plan are listed in Table 4.

Table 4. Covered Adult Wellness Evaluations or Interventions

Age/Age Range	Frequency	Evaluation or Intervention
From age 22	Annually	History and Physical Examination
From age 22 years	Annually	Multiphasic chemistry screening, to include cholesterol and high-density lipoprotein (HDL) level (or lipid panel, if indicated by history)
From age 22 years	Annually	Hemoglobin
From age 22 years	Annually	Urinalysis
From age 22 years	Annually	Screen for cervical dysplasia (Pap Smear)
From age 22 years	Annually	Electrocardiogram
Women between age 35 years and 39 years (if indicated by family history)	Once	Baseline Mammogram
Women from age 40 years	Annually	Mammogram
From age 45 years	Annually	Stool Examination for Presence of Blood
From age 50 years (for average risk individual)	Every 5 years	Colonoscopy
Males from age 40 years through age 75 years	Annually	Prostate-Specific Antigen (PSA)
From age 35 years	Every 2 years	Intraocular Pressure (Glaucoma) Test
Women within 3 – 5 years after menopause or age 65 years or older (if never screened)	Once	Bone Densitometry (Osteoporosis Screening)
Men age 70 years or older	Once	Bone Densitometry (Osteoporosis Screening)
From age 22 years	Annually	Influenza vaccine
Women between age 22 years and 26 years (if not yet immunized)	Once	Three-dose series of human papilloma virus (HPV [cervical cancer]) vaccine
From age 22 years (if not immune or previously immunized)	Once	One- to two-dose series of varicella (chickenpox) vaccine
From age 22 years (if not immune or previously immunized)	Once	Two-dose series of measles-mumps-rubella vaccine
From age 22 years (but not prior to 10 years since last tetanus booster)	Once	Tetanus-diphtheria (Td) booster vaccination (with pertussis-containing vaccine [Tdap] the first time, if less than 65 years of age)
From age 35 years	Every 2 years	Glaucoma eye test

Below is a list of additional preventive services covered at no cost sharing in accordance with the Patient Protection and Affordable Care Act (PPACA).

Preventive Services for Adults

- Abdominal Aortic Aneurysm - one time screening for men of specified ages who have ever smoked
- Alcohol Misuse - screening and counseling
- Aspirin - use for men and women of certain ages
- Blood Pressure - screening for all adults
- Cholesterol screening - for adults of certain ages or at higher risk
- Depression - screening for adults
- Type 2 Diabetes - screening for adults with high blood pressure
- Diet - counseling for adults at higher risk for chronic disease (Nutritional counseling limited to 2 visits per year)
- HIV - screening for all adults at higher risk
- Immunization vaccines for adults - doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza (Flu Shot)
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- Obesity - screening and counseling for all adults
- Sexually Transmitted Infection (STI) - prevention counseling for adults at higher risk
- Tobacco Use - screening for all adults and cessation interventions for tobacco users
- Syphilis - screening for all adults at higher risk

Preventive Services for Women, Including Pregnant Women

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women a higher risk
- Breast Cancer Mammography screenings every 1 year for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for Younger women and other women at higher risk
- Contraception: Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient Drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infection (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services for women under 65:
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella

Covered Preventive Services for Children

- Iron supplements for Children ages 6-12 months at risk for anemia
- Lead screening for Children at risk of exposure
- Medical History for all Children throughout development ages 0-17 years
- Obesity screening and counseling
- Oral Health risk assessment for Young Children ages 0-10 years
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for Children at higher risk of tuberculosis ages 0-17 years
- Vision screening for all Children

PRESCRIPTION DRUG BENEFITS

The following Prescription Drug Benefit Section applies for all Plans that have elected Prescription Coverage. Please contact Your Employer or refer to Your ID Card to see which Rx Option You are enrolled in.

REFER TO ATTACHED SCHEDULE OF BENEFITS FOR DETAILED PLAN DESIGN COMPONENTS.

Definition You Need To Know

Prescription Drugs – Drugs, biologicals and compound prescriptions that are sold only by prescription and are required to show on the manufacturer's label the words "Caution-Federal Law Prohibits Dispensing Without a Prescription," or other Drugs and devices as determined by the Plan, such as insulin. The Plan covers only Drugs that are:

- Approved for treatment of Your Illness or Injury by the Food and Drug Administration (FDA);
- Approved by the FDA for the treatment of a particular diagnosis or Condition other than Your Condition, and recognized as appropriate medical treatment for Your diagnosis or Condition in one or more of the following established reference compendia: "The American Medical Association Drug Evaluations," "The American Hospital Formulary Service Drug Information" or "The United States Pharmacopoeia Drug Information;" or
- Recommended by a clinical study and by a review article in a major peer-reviewed professional journal.

The Plan does not pay for Drugs that are limited by federal law for investigational use, or any use which the FDA determines to be contraindicated for the specific treatment for which the drug is prescribed.

Express Scripts is the administrator of the Pharmacy drug plan. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

How does my prescription Plan work?

The Affiliated Physicians and Employers Health Plan will issue a combined medical/prescription ID card to You (except for Plan C, I, and K Members. Prescription ID Cards for Plan C, I, and K Members will be issued directly from **Express Scripts**). Just present Your ID card to Your pharmacist when You fill a prescription. Chances are Your Pharmacy already participates in the network. The card contains all the information Your pharmacist needs, there is nothing else that You need to do and no claim forms to submit. You will be asked to pay the retail pharmacist Your co-payment or Deductible amount as detailed in the Schedule of Benefits for Your Plan. Retail quantities dispensed will be as written on the previous prescription order or refill, to a maximum of a 30 day supply.

What are my copayments for prescription Drugs?

The copayment and/or Deductible is applied to each covered Pharmacy drug charge and is shown in the Prescription Benefit Plan Summary above. The copayment and/or Deductible amount is not a covered charge under the Medical Plan.

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.
(2) Refills up to one year from the date of order by a Physician.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, the amount payable by the Covered Person in excess of the copayment will be the ingredient cost and dispensing fee.

How can I obtain prescriptions by mail?

If You are taking Drugs for the treatment of a chronic Condition on a long-term basis You may wish to consider the convenience and savings offered by the mail order Pharmacy. Up to a 90 day supply may be obtained on a non-Emergency basis through mail order. The medication can be shipped directly to Your home. You will be required to pay the co-payment as outlined previously, the Plan will pay the remainder of the cost of Your prescription. Information on the mail order Pharmacy and instructions for use are included with Your Welcome Package from Express Scripts, or You may call the number listed on the back of Your identification card.

Preferred Formulary List

Your Preferred Formulary List is intended to serve as a voluntary guide in selecting clinically and therapeutically appropriate medications in a cost-effective manner. It is not intended to set a standard of care, nor is it intended to take the place of a Physician's or pharmacist's judgment with regard to a patient's pharmaceutical care. Information on the preferred medications is provided in the Preferred Formulary List. Additional copies of the List can be obtained by calling the number on the back of Your identification card. We suggest You review this information and show the Preferred Medication list to Your Physician. If You wish to take advantage of the cost savings available to You, ask Your Physician to prescribe medications from this list whenever appropriate. Your Physician may want to keep a copy of the List with Your medical file to facilitate future prescribing.

What about generic Drugs?

You will always enjoy the lowest possible co-pay by using generic equivalent medications. If You wish to take advantage of this savings opportunity, ask Your Physician to prescribe Your medication generically. This will enable Your pharmacist to supply the generic

equivalent when one is available. You may also consult with Your pharmacist regarding Generic Drug options for any brand name medication You are currently taking.

How to find a participating Pharmacy?

To locate the nearest participating Pharmacy, obtain information about Your coverage, or to obtain assistance with service related matters, feel free to contact the number on the back of Your identification card. When inquiring, have Your identification card ready, which contains Your Plan Sponsor name and personal identification number. Service representatives who know Your Plan design are available 7 days a week; 24 hours a day.

What happens if I use a non-network Pharmacy?

It is to Your advantage to use a participating Pharmacy. In the rare event that You go to a non-participating Pharmacy or are unable to provide Your pharmacist with the necessary eligibility information, You may manually submit a Direct Reimbursement Claim Form. Be sure to obtain a complete Prescription Drug receipt which includes the amount charged, prescription number, name of drug dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. You will be reimbursed only if the drug is covered under the program and for only the amount that would have been paid to the participating Pharmacy, minus any applicable co-payment. This amount may be significantly lower than the retail price You paid.

What if I need Specialty Medications?

Specialty Medications are Drugs that are used to treat complex Conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. You must use our dedicated specialty Pharmacy, Accredo Health Group, Inc., in order to have coverage for Specialty Medications. Accredo Health Group, Inc., an Express Scripts specialty Pharmacy, is composed of therapy-specific teams that provide an enhanced level of personalized service to patients with special therapy needs.

Whether Your Specialty Medications are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. By ordering Your specialty medications through Accredo, You can receive:

- Toll-free access to specialty-trained pharmacists and Nurses 24 hours a day, 7 days a week
- Expedited, scheduled delivery of Your medications at no additional charge
- Necessary supplies, such as needles and syringes, provided with Your medications
- Safety checks to help prevent potential drug interactions
- Refill reminders
- Health and safety monitoring
- Up to a **90-day supply** of Your specialty medication for just one co-payment.

For more information about Accredo, or to order Your specialty medications, please call the number on Your ID card.

Coverage management programs

Under Your plan, Express Scripts is required to review prescriptions for certain medications with Your doctor before they can be covered. There are three Coverage Management programs under Your plan: Prior Authorization, Qualification by History, and Quantity Management. These are in place to help the Plan to continue providing affordable healthcare options. Contact Express Scripts to determine if You or a family Member is taking a Prescription Drug that may require review or Pre-authorization in order for them to be covered by Your plan.

- Prior authorization. Some medications require that You obtain approval through a coverage review before the medication can be covered under Your plan. The coverage review process for prior authorization will allow Express Scripts to obtain more information about Your treatment (information that is not available on Your original prescription) in determining whether a given medication qualifies for coverage under Your plan.

- Qualification by history. Some medications may also require a coverage review based on:
  -Whether certain criteria have been met, such as age, sex, or Condition; and/or,
  -Whether treatment of an alternate therapy or course of treatment has failed or is not appropriate.

  In either of these instances, Express Scripts pharmacists will review the prescription to ensure that all criteria required for a certain medication have been met. If the criteria have not been met, a coverage review will be required. If so, Express Scripts will automatically notify the pharmacist, who will in turn tell You that the prescription needs to be reviewed for prior authorization. If You know in advance that Your prescription requires a coverage review, ask Your doctor to call the coverage management team before You go to the Pharmacy.

- Quantity management. To promote safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on product labeling or clinical guidelines and are subject to periodic review and change. Examples include anti-migraine Drugs, rheumatoid arthritis and osteoarthritis Drugs, impotence Drugs, sleep aids, and pain management Drugs.

- Step Therapy Program. A prior authorization program that encourages the use of cost effective, therapeutically appropriate medications before other, more costly prescription medication options are considered. Often, the most cost-effective therapeutic option is a generic medication. Generic medications have been certified by the Food and Drug Administration (FDA) to be just as safe and effective as their brand name counterparts. They can offer a considerable economic benefit to

You. (At any time, Your Physician can request authorization to continue coverage for a Step Therapy medication for medical reasons.)

- Other programs may exists. For more information, call the toll-free number on Your ID card. Once Your coverage begins, You can access information about Your Plan and claims history, price Your medications and more at Your customized website, express-script.com.

If a coverage review is required

To arrange a review, You, Your doctor, or pharmacist should call Express Scripts at the number listed on Your ID card, 8:00 a.m. to 9:00 p.m., Eastern time, Monday through Friday. If prior authorization is not obtained, You will be responsible for the full cost of the medication at retail. If You mail in the prescription to the Medco Pharmacy, Your prescription will be returned unfilled. If coverage is approved, You will pay Your normal copayment or coinsurance for the medication.

Preferred Drug Step Therapy (PDST) Program. Coverage under this program may require that You try a Generic Drug or lower-cost brand-name alternative drug before using a higher cost non-preferred Drugs. If Your doctor believes You should use a drug that is not part of the PDST Program, then, You or Your doctor can request a coverage review by calling the number listed on Your ID Card. If the review is approved, You will pay Your plan's appropriate brand-name co-payment and/or Deductible for the medication, which may be higher than what You would pay for the plan-preferred alternatives.

Retail Refill Allowance (RRA) Program. For long-term prescriptions, use the mail order Pharmacy to avoid paying more. You'll pay more for Your long-term Drugs (such as those used to treat high blood pressure or high cholesterol) unless You order Your prescriptions through the mail by using the **mail order Pharmacy.** After Your **third purchase** of a Prescription Drug at retail, You'll pay more. The first **three times** that You purchase a long-term drug at a participating retail Pharmacy, You'll pay Your retail co-payment. After the third purchase, You'll pay a **higher cost** if You continue to purchase it at retail. To avoid paying more, use the **mail order Pharmacy** and pay Your mail-order co-payment for up to a 90-day supply. If the cost of a medication at a retail Pharmacy is lower than Your plan's retail co-payment, You will not pay more than the retail Pharmacy's cash price, regardless of the number of times You purchase the medication. In some cases, this price may be less than either Your standard retail or mail co-payment.

Dispense as Written (DAW) Program. This program allows Members to save by using Generic Drugs by automatically filling Your prescription with the low cost generic alternative to save both You and the Plan. If You request the brand-name mediation when a generic equivalent is available, You will pay the applicable co-payment, plus the difference in cost between the brand and the generic.

Which Drugs are covered?

Your prescription Plan covers most Medically Necessary and Appropriate Federal Legend, State Restricted and Compounded Medications, which by law may not be dispensed without a prescription order. An abbreviated summary of the exclusions to this are listed below. Your pharmacist has on line access to Your Plan design information and can readily see which Drugs are covered under Your plan, or You can contact our customer service center to inquire about coverage for a specific drug. Prescription Drug programs do not cover any over the counter Drugs, medical supplies or devices even if purchased at a Pharmacy, and even if a prescription order is written.

Which medications are not covered?

- Medications which do not require a prescription order, even if one is written, and medications which are not considered essential for the necessary care and treatment of an Injury or Sickness.
- Medications, which are not prescribed in accordance with FDA, approved uses. And any drug prescribed or dispensed in a manner contrary to normal medical practices.
- Medications administered by a Physician or prescriber, and those not dispensed at a Pharmacy such as those You receive at Your doctor's office, in a Hospital, clinic or other care facility.
- Medications for which the cost is recoverable under a government program, worker's compensation, or occupational disease law. And medications for which no charge is made to You.
- Immunization agents, allergy sera, biological sera, and charges for the administration or injection of Drugs.
- Any drug labeled "Caution - limited by Federal Law to Investigational Use" or experimental Drugs, even though a charge is made to You.

Other Exclusions

Several categories of Drugs are excluded from Your plan:

- Legend vitamins, except for Prenatal vitamins for Pregnancy
- Any over the counter medications
- Male sexual dysfunction Drugs
- Medications for treatment of Infertility, unless the Infertility Rider has been purchased
- Medications prescribed for weight control purposes
- Genetically engineered Drugs and growth hormones
- Drugs prescribed for cosmetic purposes and hair loss medications
- Needles, syringes, and injection devices (except with insulin)
- Certain injectables, such as injectable forms of fertility, etc. (except prescription insulin)

Prescription Appeals:

Stage 1 Appeal: In the event You receive an adverse benefit determination following a request for coverage of a prescription benefit claims, You have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate an appeal for coverage, provide in writing Your name, Member ID, phone number, the Prescription Drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to **Express Scripts., 8111 Royal Ridge Parkway, Irving, TX 75063.** A decision regarding Your appeal will be sent to You within 15 days of receipt of Your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to Your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to receive, upon request and at no charge, the information used to review Your appeal.

Stage 2 Appeal: If You are not satisfied with the coverage decision made on appeal, You may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate a second level appeal, provide in writing Your name, Member ID, phone number, the Prescription Drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to Your appeal. This information should be mailed to **Express Scripts, 8111 Royal Ridge Parkway, Irving, TX 75063.** You have the right to review Your file and present evidence and testimony as part of Your appeal, and the right to a full and fair impartial review of Your claim. A decision regarding Your request will be sent to You in writing within 15 days of receipt of Your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the Plan in relation to Your appeal, the Plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review Your second level appeal. If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal or Your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA, You also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving Urgent Care, You will be notified of the benefit determination within 24 hours of receipt of the claim. An Urgent Care claim is any claim for treatment with respect to which the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, You will be notified within 24 hours after receipt of Your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receipt of the information. If You don't provide the needed information within the 48 hour period, Your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if You request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or Your Physician may call 800-864-1135 or send a written request to **Express Scripts., 8111 Royal Ridge Parkway, Irving, TX 75063, Attn: Urgent Appeals.** In the case of an urgent appeal for coverage involving Urgent Care, You will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review Your appeal. If new information is received and considered or relied upon in the review of Your appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if Your appeal is denied or Your adverse benefit determination notice or final adverse benefit determination notice does not contain all of the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize Your life or health or Your ability to regain maximum function You could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided You simultaneously file Your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

WHAT'S NOT COVERED?
PLAN EXCLUSIONS

The following Plan Exclusions apply for **all Benefit Plans,** Offered by the Affiliated Physician & Employers Health Plan.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan Section of this document.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Acupuncture.** Except when used as a substitute for other forms of anesthesia or pain management when Medically Necessary and Appropriate.

(2) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.

(3) **Alternative Medicine Services.**

(4) **Ambulance services** for transportation from a Hospital or other health facility, unless You are being transferred to another inpatient health care facility, including Ambulance service to home or after discharge.

(5) **Armed Forces.** Condition which results from participation in a civil insurrection, riot, duty as a Member of the armed forces of any country or state of war (whether the war is declared or undeclared).

(6) **Bereavement Counseling.**

(7) **Blood or blood plasma** that is replaced by or for a Covered Person.

(8) **Childbirth classes** are not a covered benefit under the Plan.

(9) **Clinical trial.** The Plan does not cover the cost of Clinical Trials. However, the Plan covers routine costs for patients enrolled in clinical trials for life-threatening diseases, for services that would normally be covered, i.e., lab work and diagnostic testing. These services are covered by the Plan and are subject to network and out-of-network provider benefits.

(10) **Completion of claim forms.**

(11) **Complications of non-covered treatments.** Care, services or treatment required as a result of complication from a treatment not covered under the Plan.

(12) **Cosmetic Surgery.** Services or supplies for cosmetic purposes, that is, for the primary purpose of changing or improving appearance rather than to restore bodily function or to repair damage caused by an accidental Injury (Surgery must take place in the Calendar Year of or the Calendar Year following the accident), disease, birth defects or prior therapeutic treatment.

This exclusion includes surgical excision or reformation of any sagging skin on any part of the body, including but not limited to, the eyelids, face, neck, arms, abdomen, legs or buttocks; and services performed in connection with enlargement, reduction, implantation or change in appearance of a portion of the body, including but not limited to, the ears, lips, chin, jaw, nose, or breasts (except reconstruction for post-mastectomy patients).

This exclusion does not apply to otherwise Covered Services necessary to correct medically diagnosed congenital defects and birth abnormalities.

(13) **Court Ordered Treatment**, unless it meets Medical Necessity and Appropriateness criteria.

(14) **Counseling.** Counseling services that are not Medically Necessary and Appropriate in the treatment of a diagnosed medical Condition, including, but not limited to: educational counseling, vocational counseling, employment counseling, nutritional counseling, counseling for social or social-economic purposes, diabetic self-education programs, stress management, lifestyle modification, Bereavement Counseling, Marriage Counseling and Financial Counseling Services

(15) **Covered under another law.** Services provided for the treatment of any Condition, disease, Illness or Injury that's covered under any Workers' Compensation Law, Occupational Law, Occupational Disease Law, or any similar law.

(16) **Custodial Care.** Services or supplies provided mainly as a rest care, maintenance or Custodial Care.

(17) **Dental Service & Appliances.** Dental care, including but not limited to treatment of teeth, extraction of teeth which are not impacted by bone, treatment of dental abscesses or granuloma, treatment of gingival tissues (other than for tumors), dental examinations, orthognathic Surgery to treat non-traumatic jaw deformity, Orthodontic appliances and any other dental product or service.

(18) **Diagnostic Testing.** Diagnostic Testing in connection with school exams, athletic exams, pre-marital exams or employment physicals are not covered unless specifically listed in the "Preventive Care" section.

(19) **Education/Vocational Training or Testing.** Charges for educational, special education, or job training, whether or not given in a facility providing medical or psychiatric care. Services for educational or vocational testing or training. However, diabetic education is covered.

(20) **Elective Ambulance.** Including Ambulance service to home or after discharge.

(21) **Excess Charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Plan Allowable Charge.

(22) **Exercise Programs.** Exercise Programs for treatment of any Condition, except for Physician-supervised cardiac rehabilitation, occupational or Physical Therapy covered by this Plan.

(23) **Experimental or not Medically Necessary and Appropriate.** Care and treatment that is Experimental/Investigational, Research, Screening or not Medically Necessary and Appropriate unless specified as a covered service in the section "Medical Benefits – Covered Services." If any Experimental or Investigational services or supplies are provided in the course of a clinical trial, some routine patient costs for items and services furnished in connection with participation in a clinical trial may be covered, but only if those items and services would otherwise be provided under the Plan.

Routine costs do not include any of the following:

- The Experimental/Investigational drug, biological product, device, medical treatment or procedure itself.
- The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Clinical Trial.

(24) **Extraction of Teeth.** Except for bony impacted teeth.

(25) **Eye Care.** All procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses including, but not limited to radial keratotomy and refractive keratoplasty or other eye Surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, unless such care is specifically covered in the Schedule of Benefits. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(26) **Orthoptics, Vision training, low vision aids or supplemental training.** Eye exercises are specifically excluded, because vision therapy, optometric training, eye exercises or orthoptics are considered Experimental, Investigational or unproven for any indication including the management of visual disorders and learning disabilities.

(27) **Foot Care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease), fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet or other routine podiatry care, unless associated with peripheral vascular disease and/or diabetes and deemed Medically Necessary and Appropriate by the Primary Care Physician.

(28) **Foreign Travel.** Care, treatment or supplies outside the United States if travel is for the sole purpose of obtaining medical services.

(29) **Gastric Bypass, Lap Band Surgery or Weight Loss Surgery.** Surgery unless deemed Medically Necessary and Appropriate and meets medical criteria for Morbid Obesity.

(30) **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(31) **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, hair weaving or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs due to Injury, disease or treatment of a disease.

(32) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an unusual activity which is categorized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, private piloting, hang gliding, jet ski operating or bungee jumping.

(33) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting including cochlear electromagnetic hearing devices; and, routine hearing examinations, with the exception of Medically Necessary and Appropriate hearing aids for Children under the age of 16. Services and supplies related to these items are not covered. This exclusion does not apply to screening for newborn hearing loss and monitoring of infants for delayed onset of hearing loss.

(34) **Health Awareness.** Dietary instruction, educational services, behavior modification, literature, Membership in health clubs, exercise equipment, and preventive programs other than those specifically listed as covered.

(35) **Herbal Medicine.**

(36) In regard to **Hospice Care:**
a. Research studies directed to life lengthening methods of treatment;
b. Expenses incurred in regard to the Member's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property); or

(37) **Hospital Employees.** Professional services billed by a Physician or Nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(38) **Housekeeping.** Charges for housekeeping services.

(39) **Hypnotism.**

(40) **Illegal Acts.** Charges for services or supplies received as a result of Injury or Sickness caused by or contributed to by a Covered Person's engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, assault or other felonious behavior, or by participating in a riot or public disturbance; provided, however, that this exclusion does not apply to Injuries that result from acts of domestic violence or to Injuries or Sicknesses that result from medical Conditions.

(41) **Illegal Drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

(42) **Immunizations** required for employment, or travel

(43) **Impotence.** Care, treatment, services, supplies or medication to treat sexual inadequacies or dysfunction.

(44) **Infertility Services.** For or in connection with in vitro fertilization, artificial insemination or similar procedures. Only work up to determine the diagnosis of Infertility is covered.

(45) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary and Appropriate or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(46) **Medication / Supplements.** Excludes the following types of medication:
(1) **Impotence.** Care, treatment, services, supplies or medication to treat sexual inadequacies or dysfunction.
(2) **Herbal Medication**
(3) **Methadone Maintenance.**
(4) Medication furnished by any other medical service for which no charge is made to the Member.
(5) Outpatient Prescription Drugs and medications; medications that may be dispensed without a doctor's Prescription Order;
(6) **Nutritional Supplements**, except when the Member has no other source of nutritional intake due to a metabolic or anatomic disorder;
(7) **Megavitamin Therapy and orthomolecular psychiatric therapy.**

(47) **Military and Armed Forces.** Services for any Illness or Injury occurring during military service. Care related to military service disabilities and Conditions which the Member is legally entitled to receive at government facilities which are not Network Providers, and which are reasonably accessible to the Member. Condition which results from participation in a civil insurrection, riot, duty as a Member of the armed forces of any country or state of war (whether the war is declared or undeclared).

(48) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(49) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(50) **Non-Mental Illness.** Services for or in connection with the following when not specifically the result of mental Illness: Social maladjustment, Behavior, Lack of discipline or other antisocial action

(51) Services, treatments and supplies which are **not specified as covered** under this Plan would be covered if determined to be Medically Necessary and Appropriate and not specifically excluded.

(52) **Obesity.** Charges for weight reduction Surgery (unless Medically Necessary and Appropriate due to Morbid Obesity) or weight control programs, charges for nutritional supplements, special diets (unless for medical food and low protein modified food products for inherited metabolic diseases when diagnosed and determined to be Medically Necessary and Appropriate by the treating Physician), vitamins, charges for Drugs or supplements for weight gain or loss.

(53) **Occupational.** Care and treatment of an Injury or Sickness that is occupational-that is, arises from work for wage or profit including self-employment.

(54) **Organ Donor.** Services required by a Member donor related to organ donation. Expenses for Member donors donating organs to Member recipients are covered only as described. No payment will be made for human organs which are sold rather than donated;

(55) **Orthodontic appliances.**

(56) **Personal Comfort Items & Services.** Personal comfort items and services or other equipment for which any of the following statements are true and is not DME will not be covered. Any item:

a. **That is for comfort or convenience.** Items not covered include, but are not limited to: massage devices and equipment; portable whirlpool pumps, and telephone alert systems; telephone; television; bed-wetting alarms; orthopedic mattress; non-Hospital adjustable beds; customized wheelchairs; and ramps.
b. **That is for environmental control.** Items not covered include, but are not limited to: air cleansers/purification units; air Conditioners; dehumidifiers; portable room heaters / electric heating units; and ambient heating and cooling equipment.
c. **That is inappropriate for home use.** This is an item that generally requires professional supervision for proper operation. Items not covered include, but are not limited to: diathermy machines; medcolator; pulse tachometer; traction units; translift chairs; and any devices used in the transmission of data for telemedicine purposes.
d. **That is a non-reusable supply or is not a rental type item,** other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not covered include, but are not limited to: blood pressure instruments; scales; elastic bandages; incontinence pads; lambs wool pads; ace bandages; non-prescription Drugs and medicines; first aid supplies; anti-embolism stockings; catheters (non-urinary); face masks (surgical); disposable gloves; sheets and bags; and irrigating kits. This does not apply to supplies used for the treatment of diabetes as described in the Diabetic Supplies section of the Summary Plan Description.
e. **That is not primarily medical in nature.** Equipment, which is primarily and customarily used for a non-medical purpose may or may not be considered "medical" equipment. This is true even though the item has some remote medically related use. Items not covered include, but are not limited to: ear plugs; exercise equipment; ice pack; speech teaching machines; strollers; silverware/utensils; feeding chairs; toileting systems; toilet seats; bathtub lifts; elevators; stair glides; and electronically-controlled heating and cooling units for pain relief.
f. **That has features of a medical nature which are not required by the patient's Condition, such as a gait trainer.** The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists is a realistic feasible alternative item that serves essentially the same purpose and is Medically Necessary and Appropriate.
g. **That duplicates or supplements existing equipment for use when traveling or for an additional residence.** For example, a patient who lives in the Northeast for six months of the year, and in the Southeast for the other six would not be eligible for two identical items, or one for each living space.
h. **Which is not customarily billed for by the Provider.** Items not covered include, but are not limited to: barber or beauty service and similar incidental services; delivery, set-up and service activities (such as routine maintenance, service, or cleaning) and installation and labor of rented or purchased equipment.
i. **That modifies vehicles, dwellings, and other structures.** This includes (i) any modifications made to a vehicle, dwelling or other structure to accommodate a person's disability or (ii) any modifications to accommodate a vehicle, dwelling or other structure for the DME item such as a wheelchair.
j. **Replacements or Repairs of DME or Prosthetics the item due to abuse or loss.**

In regard to Home Health Care Services and Supplies in connection with Home Health services for the following:

k. Custodial services, food, housing, homemaker services, housekeeping, home delivered meals and supplementary dietary assistance;
l. Provided by family Members, relatives, and friends;
m. A Member's transportation, including services provided by voluntary Ambulance associations for which the Member is not obligated to pay;

n. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
o. Services provided to individuals (other than a Member released from an Inpatient maternity stay), or as otherwise specified in the Home Health Care provision;
p. Visits by any Provider personnel solely for the purpose of assessing a Member's Condition and determining whether or not the Member requires and qualifies for Home Health Care Services and will or will not be provided services by the Provider.

(57) **Physical Examinations.** For routine physical examinations not required for health reasons including but not related to, employment, insurance, government license, and court-ordered forensic or custodial evaluations. Also, for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel; and examinations for insurance, licensing and employment.

(58) **Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.

(59) **Primal Therapy**. Environmental ecological treatments, primal therapy, bioenergetic therapy, carbon dioxide therapy.

(60) **Psychodrama.**

(61) **Reasonable and Customary.** To the extent charges are in excess of the Reasonable and Customary charges.

(62) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.

(63) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical Condition to make the original device no longer functional.

(64) **Rest cures, sanatorium or convalescent care.**

(65) **School System Coverage**. Services or items any school system is required to provide.

(66) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(67) **Sex Changes.** Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations. As well as care, services or treatment for non-congenital transsexualism, gender dysphia or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, Surgery, medical or psychiatric treatment.

(68) **Sleep Disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary and Appropriate.

(69) **Supplements.** Vitamins, minerals, food supplements or substitutes.

(70) **Support Items.** Trusses, corsets and other support items.

(71) **Surgical sterilization and reversal of sterilization.** Care and treatment for reversal of surgical sterilization, with the exception of female sterilization.

(72) **Surrogacy.** Fees incurred and maternity services for the Maternity services provided to a Gestational Carrier or Surrogate.

(73) **Telephone consultations.**

(74) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including TMJ syndrome.

(75) Therapy - Primal Therapy. Environmental ecological treatments, primal therapy, bioenergetic therapy, carbon dioxide therapy. **Megavitamin Therapy and Orthomolecular Psychiatric Therapy. Rolfing**

For Alternative Therapies/Complementary Medicine, including but not limited to: music therapy; dance therapy; equestrian/hippotherapy; homeopathy; primal therapy; rolfing; psychodrama; vitamin or other dietary supplements (except for Medical Foods and non-standard infant formula) and therapy; naturopathy; hypnotherapy; bioenergetic therapy; Qi Gong; ayurvedic therapy; aromatherapy; massage therapy; therapeutic touch; recreational therapy; wilderness therapy; educational therapy; obesity control therapy.

(76) **Timely Filing of Claims.** Claims submitted after the 180th day following the date of service will not be considered eligible for coverage under this Plan and will be the responsibility of the Plan Participant.

(77) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for Ambulance charges as defined as a covered expense.

(78) **Umbilical Cord Preservation.**

(79) **War.** Any loss that is due to a declared or undeclared act of war.

(80) **Weight Reduction Programs.** Including all Diagnostic Testing related to weight reduction programs, unless Medically Necessary and Appropriate. Charges for weight control programs, special diets (unless for medical food and low protein modified food products for inherited metabolic diseases when diagnosed and determined to be Medically Necessary and Appropriate by the treating Physician), vitamins, charges for Drugs or supplements for weight gain or loss.
Exercise Programs & Health Awareness. Exercise Programs for treatment of any Condition, except for Physician-supervised cardiac rehabilitation, occupational or Physical Therapy covered by this Plan. Dietary instruction, educational services, behavior modification, literature, Membership in health clubs, exercise equipment, and preventive programs other than those specifically listed as covered.

(81) **Wigs, toupees, hair transplants, hair weaving or any drug,** if such drug is used in connection with baldness (with the exception of wigs after Chemotherapy or burns, up to $500 maximum benefit).

(82) **Workers' Compensation Benefits.** Any Sickness or Injury for which the Covered Person is paid benefits, or may be paid benefits if claimed, if the Covered Person is covered or required to be covered by Workers' Compensation. In addition, if the Covered Person enters into a settlement giving up rights to recover past or future medical benefits under a Workers' Compensation law, the Plan shall not cover past or future Medical Services that are the subject of or related to that settlement. Furthermore, if the Covered Person is covered by a Worker's Compensation program that limits benefits if other than specified health care providers are used and the Covered Person receives care or services from a health care provider not specified by the program, the Plan shall not cover the balance of any costs remaining after the program has paid.

(83) **Veterans' Administration Hospitals.** Coverage for Veterans' Administration Hospitals are covered only when services or treatment are for a non-service related Injury or non-service Emergency. Benefits will be payable based on the providers participation.

(84) **Modification to a home or automobile** to make it accessible and drivable by an individual with a disability.

(85) The following are not covered benefits when **provided by non-participating or Out-of-Network Providers** as described in the Schedule of Benefits:

- Home Health Care
- Durable Medical Equipment
- Chiropractic Care
- Routine Vision Care
- Outpatient Elective Surgery at a free standing surgical center (facility charges in excess of $1,000 only)
- Routine Podiatric Services
- Routine Wellness Services

(86) Any service provided by an **Out-of-Network or Non-Participating Provider** for Covered Persons enrolled in any benefit Plan with **no** Out-of-Network coverage, unless otherwise specified in this document.

MEDICAL MANAGEMENT SERVICES

MEDICAL MANAGEMENT SERVICES PHONE NUMBER: (888) 670-8135
YOU MUST CALL TO VERIFY BENEFITS AND ELIGIBILITY, MEDICAL MANAGEMENT FOR PRE-AUTHORIZATION.

The following Medical Management Guidelines apply for all Benefit Plans offered by the Affiliated Physician & Employers Health Plan.

The patient, a family Member or a provider must call this number to receive certification for certain services that are outlined on the Pre-authorization Requirement List. This call must be made five (5) days before an elective pre-certifiable service is rendered or within 48 hours for an urgent or emergent admission.

Failure to Pre-authorize required services will result in a benefit penalty. Refer to the Schedule of Benefits for details on Pre-authorization penalties. Any penalty due to failure to follow utilization management procedures will not accrue toward the 100% maximum out-of-pocket payment.

MEDICAL NECESSITY AND APPRORIATENESS

The Plan provides payment for benefits when services are:

- performed or prescribed by a Physician; and
- provided at the proper level of care (inpatient, outpatient or outside of the Hospital).

In addition, the Plan only covers services or supplies that are *Medically Necessary and Appropriate* for the treatment or diagnosis of a Sickness or Injury, and meet the nationally recognized guidelines established to determine Medical Necessity and Appropriateness.

The Plan uses specific medical guidelines to make a determination on care that is provided in either an inpatient or outpatient setting. This means that even though a Physician may prescribe a service or supply, the Plan may not consider that service or supply as Medically Necessary and Appropriate for the treatment or diagnosis of a Sickness or Injury based on specific medical guidelines. If the Plan determines that an eligible service can be provided in an alternate setting that is medically acceptable, then the Plan reserves the right to provide benefits for such services when performed in that alternative setting.

PRE - AUTHORIZATIONS

The Medical Management Committee of the Plan has established guidelines for participating Network Providers outlining the requirements regarding Pre-authorizations. To find out if a service requires Pre-authorization, just call the Plan hotline at 1-888-670-8135.

Definitions You Need to Know

Pre-authorization: Before a Covered Person enters the Hospital on a non-Emergency basis, the Medical Management Review Administrator will, in conjunction with the attending Physician, certify the care. A non-Emergency Hospitalization is one that can be scheduled in advance. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. Emergency admissions require Pre-authorization within 48 hours. Certain other outpatient services also require Pre-authorization. See below for a full list of services that require Pre-authorization.

SERVICES REQUIRING PRIOR AUTHORIZATION

The following services require Pre-authorization from the Medical Management Department prior to receiving services. The Member's Primary Care Physician or Specialist must contact the Medical Management Department for Pre-authorization. As a result of new technologies, prior authorizations include, but may not be limited to, the following list:

All inpatient admissions including:

- Acute Care
- Routine and high risk maternity
- Skilled Nursing
- Subacute Care
- Rehabilitation
- Hospice
- Mental Disorder and Substance Abuse
- Psychiatric Partial Hospital Stays

Note: Elective inpatient admissions require Pre-authorization at least five (5) days before the admission.
Urgent or Emergency admissions require notification within two (2) business days of admission.

Outpatient and ambulatory Surgery, regardless of the location, for only the procedures listed below:

- Blepharoplasty (eyelid Surgery)
- Cardiac catheterization (procedure to look into blood vessels)
- Endoscopic nasal sinus Surgery (procedure to look into facial cavities)
- Keloid revisions (removal of scar tissue)
- Ligation and vein stripping (tying and removal of veins)
- Mammoplasty, reduction (breast reduction)
- Mastopexy (surgical revision of a breast)
- Mastectomy for gynecomastia (removal of excess tissue from the male breast)
- Otoplasty (external ear Surgery)
- Rhinoplasty (plastic Surgery of the nose)
- Sclerotherapy (procedure for treatment of varicose veins)
- Septoplasty (reconstruction of the partition between the nasal cavities)
- Turbinectomy (removal of nasal walls)
- Uvuloplasty (Surgery of the soft palate of mouth)

Pain Management Programs/Treatment including:

- Acupuncture treatments
- Epidurals (anesthesia into the spinal canal for pain relief)
- Cryodenervation (freezing of nerves for pain relief)
- Facet Injections (injections into a spinal joint)
- Radiofrequency denervation (procedure to destroy a nerve for relief of pain)
- Evoked potential studies (test on nerve conduction)
- Sacroiliac joint injections (injection into lower back for pain relief)
- Intrathecal (spinal canal) Pumps
- Spinal cord stimulators
- Nerve and Ganglion blocks (pain management)

Other outpatient services:

- Braces, Custom fitted (support of a body part)
- Durable Medical Equipment (all rentals)
- Durable Medical Equipment (purchase greater than $500)
- Home Care, Hospice, Home Infusion
- Outpatient Infusion Therapy, excluding Cancer Chemotherapy (medicine or fluids into veins)
- Experimental/Investigational Services
- IV Therapy (Outpatient in a Facility/Doctor's office, excludes Chemotherapy administration in an office)
- Obstetrical Ultrasounds greater than three per Pregnancy (test to visualized a fetus in the uterus)
- Ankle Foot Orthotics, Custom fitted (those custom braces/orthotics made for support above and below the foot)
- Pet Scans (test to determine presence and stage of Cancer)
- MRAs
- Prosthetics (artificial body parts)
- Rehabilitation (cardiac, cognitive, occupational, physical, Speech Therapy and Chiropractic Care)
- Transplant evaluations
- Transportation Elective (non-Emergency only)

IF HOSPITALIZATION OR SURGERY IS RECOMMENDED

All non-Emergency Hospital admissions must be reviewed by the Plan before the patient is admitted. This procedure must be followed whether You use the network or out-of-network portion of the Plan, if applicable. You or Your doctor must call for Pre-authorization and request a pre-Hospital review at least five business days before the admission is scheduled (or as soon as possible).

You are also required to obtain a pre-surgical review for any non-Emergency procedure performed outside of a Physician's office. The review must be requested at least five days before the Surgery is scheduled. If the Surgery is being performed in a Hospital on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-Hospital review.

HERE'S HOW THE PROGRAM WORKS.

Pre-authorization. Before a Covered Person enters a Medical Care Facility on a non-Emergency basis or receives other listed medical services, the Medical Management Review Administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-Emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The Medical Management review program is set in motion by a telephone call from the Covered Person. Contact the Medical Management Review Administrator at the telephone number on Your ID card **at least 1 day before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of Surgery
- The proposed rendering of listed medical services

If there is an **Emergency** admission to the Medical Care Facility, the patient, patient's family Member, Medical Care Facility or attending Physician must contact the Medical Management Review Administrator **within 48 hours** of the first business day after the admission.

The Medical Management Review Administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, payment will be reduced/ or a penalty applied according to the "Schedule of Benefits."

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the Medical Management review program. The Medical Management Review Administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary and Appropriate for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

PREADMISSION TESTING SERVICE

Refer to the Schedule of Benefits for the Medical Benefits percentage payable for diagnostic lab tests and x-ray exams provided by a Provider when:

- performed on an outpatient basis within seven days before a Hospital confinement;
- related to the Condition which causes the confinement; and
- performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 100% even if tests show the Condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The Deductible will also be waived for these tests.

Preadmission testing as set forth above will be reimbursed according to the Schedule of Benefits.

CASE MANAGEMENT

When a catastrophic Condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps Lifetime care. After the person's Condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary and Appropriate care. The case manager consults with the patient, the family and the attending Physician in order to develop a Plan of care for approval by the patient's attending Physician and the patient. This Plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;

- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Claims Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Claims Administrator will direct the Plan to reimburse for Medically Necessary and Appropriate expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment Plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

Alcohol Abuse- Abuse of or addiction to alcohol.

Ambulance- A certified transportation vehicle for transporting ill or injured people that contains all life-saving equipment and staff as required by applicable state and local law.

Ambulatory Surgical Center is a Facility mainly engaged in performing Outpatient Surgery. It must be staffed by Physicians and Nurses, under the supervision of a Physician, have operating and recovery rooms, be staffed and equipped to give Emergency care, and have written backup arrangements with a local Hospital for Emergency care. It must carry out its stated purpose under all relevant state and local laws and be either: accredited for its stated purpose by either The Joint Commission or the Accreditation for Ambulatory Care, or approved for its stated purpose by Medicare. A Facility is not an Ambulatory Surgical Center, for the purpose of this document, if it is part of a Hospital.

Annual Open Enrollment Period is the 30 day period prior to the Plan's Renewal Date. During the Annual Open Enrollment Period, Covered Persons' and their Dependents will have the opportunity to change their level of coverage or choose between Plans offered. Benefit choices made during the Annual Open Enrollment Period will become effective on the Plan's Renewal Date and remain in effect for 12 months, unless there is a Qualifying Event. Refer to General Plan Information for this Plan's Annual Open Enrollment Period and Renewal date.

Automobile Related Injury means bodily Injury sustained by a Covered Person as a result of an accident: while occupying, entering, leaving or using an automobile; or as a pedestrian; caused by an automobile or by an object propelled by or from an automobile.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Benefit Plan Year is the 12 - month period beginning each January 1st or on the day following the end of the first Plan Year that is a short Plan Year, i.e., one that starts on a date other than January 1. This is the date by which all Plan Deductibles, Plan maximums, visit maximums, etc., are tracked. Refer to General Plan Information for this Plan's Benefit Year Effective Date.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered Nurse (R.N.) or a licensed Nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Civil Union is a legal union of a same-sex couple, sanctioned by a civil authority.

Clinical trial is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening Condition or disease (or other Condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening Condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted. The Plan does not cover the cost of Clinical Trials. However, the Plan covers routine costs for patients enrolled in clinical trials for life-threatening diseases, for services that would normally be covered, i.e., lab work and diagnostic testing. These services are covered by the Plan and are subject to network and Out-of-Network Provider benefits.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Condition is a disease or Illness.

Cosmetic Surgery or Procedure is any Surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate/ Medical Necessity and Appropriateness.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage means, with respect to an Employee or Dependent, coverage of the Employee or Dependent under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for Members and certain former Members of the uniformed services and their Dependents); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health Plan offered under chapter 89 of Title 5, United States Code; a public health Plan as defined by federal regulation; a Health Benefits Plan under section 5(e) of the "Peace Corps Act"; or coverage under any other type of Plan as set forth by the Commissioner of Banking and Insurance by regulation.

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of Health Benefits Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible means annual amount of covered charges for which no benefits will be paid under the Plan. Before benefits can be paid in a **Calendar Year** a Covered Person must meet the Deductible shown in the Schedule of Benefits.

Dependent.
A Dependent is any one of the following persons:
(1) Legal Spouse. The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator requires a certified copy of a marriage certificate.
(2) Domestic Partner. Domestic Partners, of any gender, who have been living in a committed exclusive relationship of mutual caring and support with the covered Employee for a period of 12 months, who intend for the Domestic Partnership to be permanent are covered under this Plan, provided that they meet the following proof requirements. It is required that You provide three documents evidencing the commitment of the relationship. The following documentation for coverage of a domestic partner is acceptable: joint mortgage or lease; designation of the Domestic Partner as a primary beneficiary for a life insurance or a retirement contract; designation of the Domestic Partner as a primary beneficiary in the Employee's will; durable power of attorney for healthcare or financial management; Joint ownership of a motor vehicle, a joint checking account or a joint credit account; a relation or cohabitation contract which obligates each of the parties to provide support for the other party. You may be required to sign an agreement with the Plan that You provide the Plan with notice within 31 days of a break in the Domestic Partnership.
(3) Civil Union Partner. Pursuant to P.L. 2006, c.103. Civil Union couples are granted all of the same rights as married couple. The Plan requires a copy of the Civil Union Certificate. Civil Union couples do not have to meet domestic partner guidelines or provide proof requirements of Domestic Partnership.
(4) Unmarried Child(ren) up to Age 31. A Dependent is eligible for coverage up to age 31 from the first day that he or she meets the Dependent definition below if they are between the age of 26 and 31. These Dependents will be subject to 102% of the single healthcare fee rate charged for the Plan in which they are enrolled in and will be covered until their 31st birthday or until the last day of the month for which the required payment has been made, whichever comes first.
(5) Child(ren) who have not attained age 26 will be eligible for coverage under the Plan. Such Children must be unmarried and be primarily Dependent upon the covered Employee for support and maintenance and do not have to be eligible to declare the Dependent Child as a tax Dependent under IRC Section 152 (Dependent defined) on the Employee's tax return as opposed to actually declaring the Dependent Child on the Employee's tax return. Documentation showing eligibility, including but not limited to, birth certificates, proof of full time college student status, marriage certificates, tax records, records of relevant legal proceedings, separation and divorce decrees must be provided to the Human Resource Department.

The term "Children" or "Child" shall include natural Children, adopted Children, foster Children or Children placed with a covered Employee in anticipation of adoption or of the Child's becoming a Member's foster Child. Step Children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household

The phrase "Child placed with a covered Employee in anticipation of adoption" refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption.

The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. Coverage of these pre-adoptive Children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. The Child must otherwise be available for adoption and the legal process must have commenced.

The phrase "primarily Dependent upon" shall mean Dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

If a covered Employee is the Legal Guardian of an unmarried Child or Children, these Children may be enrolled in this Plan as covered Dependents.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical Child support order shall be considered as having a right to Dependent coverage under this Plan. Coverage of these Children is in accordance with the requirements of the federal Omnibus Budget Reconciliation Act of 1993. This Plan's qualified medical Child support order procedures are available upon request.

(6) Legal Guardianship. Should the covered Employee have a court-appointed Legal Guardianship and is within 30 days of the date Legal Guardianship is granted, coverage for the Child becomes effective the date the Legal Guardianship is granted. A Child for whom the Employee acquires Legal Guardianship, but does not apply to enroll until more than 30 days after the date Legal Guardianship is granted, will not be eligible until the next Annual Enrollment Period.

(7) A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self sustaining employment by reason of mental or physical handicap, primarily Dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

After such two year period, the Plan may require subsequent proof not more than once each year. The Plan reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Dentist. A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific Condition or disease. Some examples are: a) radiology, ultrasound and nuclear medicine; b) laboratory and pathology; c) EKGs, EEGs and other electronic diagnostic tests. Except as allowed under Your Wellness Benefit, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion – Exclusive and unfettered right to make a decision or determination.

Domestic Partners means two individuals, who have been living in a committed exclusive relationship of mutual caring and support for a specified time period, who intend for the Domestic Partnership to be permanent, who are financially interDependent and jointly responsible for the common welfare and financial obligations of the household and who are not in the relationship solely for purposes of obtaining benefits but who are not married under applicable law. Domestic Partners shall include domestic partner pursuant to P.L. 2003, c. 246.

Drugs means Drugs as determined by the Food and Drug Administration and listed in the Formulary of the state in which they are dispensed; these Drugs are protected by the trademark registration of the pharmaceutical company which produced them.

Durable Medical Equipment means Equipment the Plan Determines to be:

a. designed and able to withstand repeated use;
b. used primarily and customarily for a medical purpose;
c. is generally not useful to a Member in the absence of an Illness or Injury; and
d. is suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, blood glucose monitors, insulin pumps, breathing equipment, oxygen, Hospital type beds, walkers, wheelchairs, wigs following Chemotherapy treatment in connection with Oncology Services.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air Conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

Effective Date- The date on which coverage begins for a Member.

Emergency means a medical Condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbance and/or symptoms of Substance Abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate attention to result in: placing the health of

the individual (or with respect to a pregnant woman, that health of the woman or her unborn Child) in serious jeopardy: serious impairment to bodily functions; or serious dysfunction of a bodily organ to part. With respect to a pregnant woman who is having contractions, an Emergency exist where: where is inadequate time to effect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or unborn Child. Examples of Medical Emergencies include, but are not limited to: heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness or respiration.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. Partners, Proprietors and independent contractors will be treated like Employees, if they meet all of the Plan's eligibility requirements. Employees who work on a temporary, part-time or substitute basis are not considered to be Employees for the purpose of this Plan.

Employer is each individual Participating Member of the Trust who has elected coverage for its eligible Employees under the Trust by completing and agreeing to the terms and Conditions of the Health Plan Participation Request/Agreement.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day following the end of the Waiting Period, if any.

ERISA is the federal Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means Services or supplies which the Plan determines are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular Condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular Condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to Drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), the Plan will not cover any services or supplies, including treatment, procedures, Drugs, biological products or medical devices or any Hospitalizations in connection with Experimental or Investigational services or supplies.

The Plan will also not cover any technology or any Hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular Condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular Condition, as explained below. The Plan will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

1. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or Condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or Condition, use of the medical device, drug or biological product for another diagnosis or Condition will require that one or more of the following established reference compendia recognize the usage as appropriate medical treatment:
   (a) The American Medical Association Drug Evaluations;
   (b) The American Hospital Formulary Service Drug Information; or
   (c) The United States Pharmacopoeia Drug Information
2. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard Conditions of medical practice, outside clinical investigatory settings.

Extended Care Center (see "Skilled Nursing Facility").

Family Unit is the covered Employee and the family Members who are covered as Dependents under the Plan.

Fee Schedule is any negotiated, discounted or per diem rate or fee that the Network (First Health or QUALCARE) may have with a particular provider. See, also Plan Allowable Charges.

Generic Drug means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family Member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Governmental Hospital is a Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

Group Health Plan means an Employee welfare benefit plan, as defined in Title I of section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. § 1002(1)) to the extent that the Plan provides medical care and includes items and services paid for as medical care to Employees or their Dependents directly or through insurance, reimbursement or otherwise.

Health Benefits Plan means any Hospital and medical expense insurance policy or certificate; health, Hospital, or medical service corporation contract or certificate; or health maintenance organization Subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992. c. 162 (C. 17B: 27A-19) or any other similar contract, policy, or Plan issued to a Small Employer, not explicitly excluded from the definition of a Health Benefits Plan. Health Benefits Plan does not include one or more, or any combination of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health Benefits Plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long term care, nursing home care, home health care, community based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. Health Benefits Plan shall not include Hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group Health Benefits Plan maintained by the same Plan Sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any Group Health Plan maintained by the same Plan Sponsor. Health Benefits Plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act; and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and similar supplemental coverage provided to coverage under a Group Health Plan.

Health Status-Related Factor means any of the following factors: health status; medical Condition, including both physical and mental illness; claims experience; receipt of health care; medical history; Genetic Information; evidence of insurability, including Conditions arising out of acts of domestic violence; and disability.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written Plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered Nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and Speech Therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a Plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered Nurses (R.N.s); and it is operated continuously with organized facilities for operative Surgery on the premises.
The definition of "Hospital" shall also include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered Nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, Childbirth, miscarriage or Complications of Pregnancy.

Infertility is a Condition that results in the abnormal function of the reproductive system such that a person is unable to:

a. impregnate another person;
b. conceive after unprotected intercourse;
c. carry a Pregnancy to live birth.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan with or without interruption. Under no circumstances does Lifetime mean during the Lifetime of the Covered Person.

Medicaid is the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Necessity and Appropriateness/ Medically Necessary and Appropriate is services or supplies, provided by a recognized Health Care Provider that are determined to be:

a. necessary for the symptoms and diagnosis or treatment of the Condition, Illness or Injury;
b. provided for the diagnosis or the direct care and treatment of the Condition, Illness or Injury;
c. in accordance with generally accepted medical practice;
d. not for the convenience of the Member or Provider of medical services;
e. the most appropriate level of medical care that a Member needs; and

f. furnished within the framework of generally accepted methods of medical management currently used in the United States. In the instance of a Medical Emergency, the fact that a Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not necessarily make the services Medically Necessary and Appropriate.

Not all Medically Necessary and Appropriate services or supplies are covered. Please refer to the Plan Exclusions section of this Summary Plan Description.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member is an eligible person who is covered under this Plan (includes Covered Employee and covered Dependents, if any).

Mental or Nervous Condition is a Condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to: psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

MEWA is a self-funded arrangement for the provision of health care benefits established by one or more unrelated Employers. A MEWA is subject to ERISA and, in New Jersey, by the provisions of the Self-Funded Multiple Employer Welfare Regulation Act (NJSA 17B: 27C-1, et seq. and the regulations promulgated pursuant to it).

Morbid Obesity is a diagnosed Condition in which the body weight exceeds the medically recommended weight. This is determined when a Covered Person has a body mass index (BMI) of greater than or equal to 40, or a BMI of greater than or equal to 35 with co-morbidities.

Network Provider or Participating Provider is a Physician, Hospital, or other health care provider who is contracted with the Plan's provider network to provide services to Plan Members for specific pre-negotiated rates.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Nurse means a registered Nurse or licensed practical Nurse, including a Nurse specialist such as a mid-wife or Nurse anesthetist, who: a) is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and b) provides medical services which are within the scope of his or her license or certificate and are covered by this Plan.

Out-of-Network Provider is a Physician, Hospital, or other health care provider, who is not contracted to participate with the Plans provider network.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Participating Member is each individual Employer of the Trust who has elected coverage for its eligible Employees under the Trust by completing and agreeing to the terms and Conditions of the Health Plan Participation Request/Contract.

Participating Provider or Network Provider is a Physician, including Hospitals, of varied specialties as well as general practice, who are contracted with the QualCare, Inc. or the Affiliated Physicians and Employers Health Plan.

Patient Protection and Affordable Care Act (PPACA) is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist

(Ph.D.), Speech Language Pathologist and any other Physician of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the GHPT Health Plan, which is a benefits Plan for certain Participating Members of the GHPT Health Plan Trust and is described in this document.

Plan's Allowable Charges are charges that do not exceed the maximum dollar amount the Plan will recognize for a covered service, procedure or supply by other Network Providers of similar profession. The Covered Person is responsible for amounts above the Plan's Allowable Charge and can be balance billed by an out-of-Network Provider.

For all Out-of-Network elective and non emergent Physician and ancillary services the Plan will not pay more than the Plan's Allowable Charge as indicated above. For all Out-of-Network elective and non emergent Hospital services the Plan will not pay more than Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule.

Charges in excess of the *Plan's Allowable Charges* are not considered covered charges under the Plan and do not accrue towards Your maximum out-of-pocket allowance.

Plan Sponsor has the meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974" (ERISA) (29 U.S.C. § 1002(16)(B)). That is:

a) the Small Employer in the case of an Employee benefit Plan established or maintained by a single Employer;
b) the Employee organization in the case of a Plan established or maintained by an Employee organization; or
c) in the case of a Plan established or maintained by two or more Employers or jointly by one or more Employers and one or more Employee organizations, the association, committee, joint board of Trustees, or other similar group of representatives of the parties who establish or maintain the Plan.

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Pre-authorization. Before a Covered Person enters the Hospital on a non-Emergency basis, the Utilization Review Administrator will, in conjunction with the attending Physician, certify the care. A non-Emergency Hospitalization is one that can be scheduled in advance. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care providers. Emergency admissions require Pre-authorization within 48 hours.

Pregnancy is Childbirth and Conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary and Appropriate in the treatment of a Sickness or Injury.

Primary Care Physician (PCP). A Participating Provider who is a doctor specializing in family practice, general practice, internal medicine, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Covered Person; initiates a Covered Person's Referral for Specialist Services (if required); and is responsible for maintaining continuity of patient care.

Reasonable and Customary (see Plan's Allowable Charges).

Referral. Specific direction or instruction from a Covered Person's Primary Care Physician in conformance with the Plan's policies and procedures that directs a Covered Person to a Facility or Provider for health care.

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Schedule of Benefits refers to the outline of Covered Benefits as shown in the Plan.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered Nurse (R.N.) or by a licensed practical Nurse (L.P.N.) under the direction of a registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed Nurses, under the direction of a full-time registered Nurse.

(4) It maintains a complete medical record on each patient.
(5) It has an effective utilization review Plan.
(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital or any other similar nomenclature.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are: a) Intensive Care Units; b) cardiac care units; c) neonatal care units; d) burn units.

Specialist Doctor is a doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

Specialty Pharmaceuticals are products that are processed through DNA technology or biological processes that target chronic disease states. Also known as Biotech Pharmaceuticals.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subscriber - A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

Substance Abuse - Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on Drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surgery -

a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures; or
b. the correction of fractures and dislocations; or
c. pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation - Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical Conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

Therapy Services - The following services or supplies ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

ABA Therapy - behavioral interventions based on the principles of applied behavioral analysis (ABA) and related to structured behavioral programs for the treatment of autism.

Cardiac Rehabilitation Therapy - program of structured outpatient supervised exercise that occurs subsequent to a major cardiac event.

Chelation Therapy - the administration of Drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy – the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy - retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic processes.

Dialysis Treatment - the treatment of acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy - the administration of antibiotic, nutrients or other therapeutic agents by direct infusion.

Occupational Therapy - treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy - the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of a limb.

Radiation Therapy - the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy - the introduction of dry or moist gases into the lungs.

Speech Therapy - treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Total Disability to Totally Disabled means, except as otherwise specified in this Plan, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is or may be suited by education, training and experience, and is not in fact, engaged in any occupation for wage or profit, A Dependent is Totally Disabled if he or she cannot engage in the norm activities of a person in good health and of like age and sex. The Employee or Dependent must be under regular care of a Physician.

Trust means the Affiliated Physicians and Employers Master Trust established by means of a Trust Agreement entered into pursuant to the provisions of the Self-Funded Multiple Employer Welfare Regulation Act (NJSA 17B: 27C-1, et seq).

Trustees means the Initial Trustees, additional persons elected or appointed as Trustees in accordance with the Trust, and any successors elected or appointed from time to time in accordance with the provisions of the Trust.

Trust Participation Request/Contract or **Health Plan Participation Request/Contract** means an agreement between (i) the Trust and (ii) a Participating Member, pursuant to which the Participating Member agrees to participate in the Trust, agrees to be bound by the terms of the Trust Agreement and identifies Eligible Beneficiaries (affiliated with such Participating Member) or sets forth the means of identifying such Eligible Beneficiaries, "Covered Persons" under this Plan.

Urgent Care includes non-Emergency Conditions for which treatment cannot reasonably be postponed, such as minor cuts, sprains or strep throat.

Usual and Customary Charge - A charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area.

Medical Management Review Administrator, assists individuals with treatment needs that extend beyond the acute care setting. The goal of of the Medical Management Review Administrator is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility.

Waiting Period means the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the Plan.

You, Your, and Yours. Refers to the Covered Person or Covered Employee.

HOW TO SUBMIT/FILE A CLAIM

HOW TO FILE A CLAIM

Be sure to refer to the following procedures when You need to file a claim.

The following section applies for **all benefit Plans**, unless specifically indicated otherwise. When You use a Network Provider, You will not have to complete any claim forms. If You use an out-of-Network Provider (if applicable), however, You and the provider will have to submit a claim for benefits to the address below with the appropriate information.

Mail Claims to:
Affiliated Physicians and Employers Health Plan **P.O. Box 219** **Piscataway, NJ 08855-0219** **Plan Hotline: 1-888-670-8135**

If You have a question about a claim, please call the Plan hotline at 1-888-670-8135. A representative will help You resolve Your claim, including verifying that Your claim is for a covered treatment.

CLAIMING YOUR BENEFITS (FILING A CLAIM)

When filing Your claim, You must submit proof of each charge. It is extremely important that You secure copies of bills for all charges. All bills should be itemized.

You must provide proof of claim and it must be furnished to the Plan Administrator within 90 days following the date services were provided. However, Your claim still will be considered if it was not possible to furnish proof within that time and the proof was furnished as soon as reasonably possible, however, no later than 180 days from the original date services were provided. Claims submitted after the 180th day following the date of service will not be considered eligible for coverage under this Plan and will be the responsibility of the covered Member.

All benefits provided by the Plan will be paid as soon as possible upon receipt of proof of claim. Benefits will be payable to the Employee unless benefits have been assigned.

No action at law or in equity may be brought against the Plan prior to the expiration of **180** days after proof of loss has been furnished, nor shall such action be brought within one year from the expiration of the time within which proof of loss is required to be furnished.

The Plan shall have the right to examine any person whose loss is the basis for the claim as often as it may reasonably require, and to perform an autopsy where not forbidden by law. The Plan is not in lieu of and does not affect any requirements for workers' compensation insurance.

ASSIGNING HEALTH CARE BENEFITS

You may authorize the Claims Administrator to make payments directly to providers for covered services. However, the Claims Administrator reserves the right to make payments directly to You. Payments may also be made to an alternate recipient or that person's custodial parent or designated representative. Any payments made by the administrator fulfill all obligations of the Plan and/or the Plan Sponsor to pay for covered services.

You cannot assign Your right to receive payment to anyone else without written consent of the Plan, except as may be required by a qualified medical Child support order (QMCSO) or any applicable state law. Once a provider performs a covered service, the administrator will not honor a request to withhold payment of the claims submitted.

IF YOUR CLAIM IS DENIED

If Your health benefits claim is denied in whole or in part, the Plan Administrator will notify You in writing or electronically of its determination within the claim notification time-frames. The Plan Administrator may determine that more time is needed, but will notify You in writing if that is the case before the end of the respective claim period. If Your claim is not filed properly, You or Your authorized representatives will be notified of that fact and of the procedures to be followed to properly file a claim.

Claim Notification Time-Frames

Urgent Care claims (adverse or not) will be decided as soon as possible, but in no event later than 72 hours from receipt of the claim. If the claim is incomplete, so that a determination cannot be made of whether benefits are covered or payable under the Plan, the Plan Administrator will notify You within 24 hours of receipt of the claim of the information needed to complete the claim. You then have 48 hours to provide the information. Once the additional information is received by the Plan Administrator, the claim will be decided within 48 hours of the earlier of:

(1) the Plan's receipt of the specified information; or
(2) the end of the period afforded to You to provide the specified additional information.

Concurrent care decisions to reduce or terminate ongoing treatment will be communicated in writing or electronically to You far enough in advance to give You time to appeal and obtain a determination on review before the benefit is reduced. Any request that You may make to extend the treatment beyond the Plan-specified time or number of treatments will be decided within 24 hours of receipt of Your request by the Plan. However, You must make the request to extend treatment at least 24 hours before the scheduled termination or reduction in treatment. Any decision by the Plan will be conveyed to You either in writing or electronically.

Pre-service claims (adverse or not) will be decided within 15 days of receipt. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, but the Plan will notify You in writing or electronically of the circumstances causing the delay and the date a determination is expected. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide You at least 45 days from receipt of the notice to provide the necessary information

Post-service claims denials will be decided and communicated to You in writing or electronically within 30 days of receipt of the claim. This determination period may be extended one time for 15 days for reasons beyond the Plan's control, in which case the Plan will notify You in writing or electronically within the first 30-day period of the circumstances requiring an extension and the expected date of a decision. If the extension is due to a faulty claim, the notice of extension will describe the needed information and provide You at least 45 days from receipt of the notice to provide the necessary information.

Disability claims. In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant of the Plan's adverse determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30 day- extension period, the administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan administrator notifies the claimant,

NOTICE OF ADVERSE DETERMINATIONS

You will be given written or electronic notice of any adverse benefit determination on Your claim. The notice will set forth:

- the specific reasons for denial;
- reference to the specific Plan provisions on which the decision is based;
- a description of any additional material or information needed for You to perfect the claim and an explanation of why the material or information is needed;
- a description of the Plan's review procedures and the applicable time limits, as well as a statement of Your right to sue;
- any specific rule, guideline, protocol or other similar criterion the decision-maker relied upon in making the adverse determination, and that a copy of the rule, guideline, etc., will be provided free, if You request a copy;
- if the decision is based on a Medical Necessity and Appropriateness or experimental treatment or similar exclusion or limitation, an explanation of the scientific or clinical judgment, or a statement that the explanation will be provided free, if You request a copy; and
- if the request involves an Urgent Care decision, a description of the applicable expedited review process.

When an Urgent Care decision is involved, information may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

APPEALS/GRIEVANCE PROCEDURES

YOUR RIGHT TO APPEAL A CLAIM

The Plan maintains an appeal/grievance procedure for the resolution of disputes arising between Covered Persons and participating Physicians or the Plan regarding adverse determinations, benefits, the operation of the Plan and the terms of this document (Summary Plan Description). The Plan will attempt to resolve appeals/grievance matters informally. If this is not successful, You have the right to have complaints reviewed by the Plan's Benefits Review Committees

Pursuant to Your appeal, You are entitled to receive free, upon request, access to and copies of all documents, records and other information relevant to the claim. You also will receive a review that takes into account all comments, documents, records and other claim-related information. The review will be conducted by a Plan fiduciary or a representative assigned by the Plan fiduciary who is neither the individual who made the initial denial nor the subordinate of such individual.

An Adverse Benefit Determination means a determination of non-approval, in whole or in part, of a pre-treatment or claim payment request, including a rescission of coverage. If the Plan Administrator denies all or part of Your claim for benefits, i.e., makes an adverse determination, You or Your beneficiary will be notified in writing. This notice will include the following:

- a reference to the date of service, health care provider, claim amount, diagnosis and treatment codes, with an explanation of their meanings;
- the specific reason why the claim was denied;
- references to applicable provisions of the Plan document, relevant records or other information (You may examine these documents; see below for more information); and
- an explanation of how to appeal the Plan Administrator's decision.

If You wish to appeal an Adverse Benefit Determination, You have 180 days from the time You are notified to request a review. Problems as to claims between You and the Plan should generally be dealt with through the post-service appeal/grievance procedures listed below. If You have an urgent or pre-service appeal, refer to the appeals sections below for more detailed information on the types of appeals and the process for requesting a review.

MEDICAL JUDGMENT OR RESCISSION OF COVERAGE APPEALS

The Plan has a procedure for resolving disputes between You and the Plan regarding decisions involving medical judgment or rescissions of coverage. For purposes of this procedure, a "decision involving medical judgment" excludes any matter that involves only contractual or legal interpretation, and includes a decision that involve medical judgment to any degree. Examples of matters involving medical judgment include, but are not limited to, determinations based on the Plan's requirements for Medical Necessity and Appropriateness, the appropriate health care setting for the Condition at issue, and whether the treatment at issue involved "Emergency care" or "Urgent Care."

STAGE 1 APPEAL: INTERNAL If You wish to appeal in writing an Adverse Benefit Determination decision, You may submit a Stage 1 claim appeal. The Plan fiduciary or a representative of the Plan fiduciary will consult with a health care professional, if necessary, who will neither be an individual who was consulted in connection with the initial decision nor the subordinate of any such individual. Upon request, You will be provided the identity of any medical or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether the advice was relied on to make the initial decision. The Plan representative will review Your appeal, make a determination on that appeal and communicate its decision to You or Your representative as described below:

- ***Urgent Care claims.*** The Plan will notify You as to its determination of a pre-service claim involving Urgent Care as soon as possible but not later than 72 hours after receipt of the claim by the Plan. This is so whether or not the determination is adverse and will take into account the medical exigencies. In the event that there is insufficient information to process the claim, You will be notified, no later than 24 hours after receipt of the claim, of the need for additional information to process it. You will have 48 hours from the date of such notice to provide the requested information. Failure to provide the necessary information within the 48-hour period described above may result in the denial of the claim.
- ***Pre-service claims.*** Decisions on review of pre-service claims (other than an urgent-care claim, which is discussed above) will be made and communicated as soon as reasonably possible, but in all cases within 15 days of the Plan's receipt of the claim.
- ***Post-service claims.*** Decisions on review of post-service claims will be made and communicated as soon as reasonably possible, but in all cases within 30 days of the Plan's receipt of the claim.

You will be permitted to review the claim file and to present evidence and written testimony as part of the internal claim appeal process. You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date in which any notice of final internal adverse benefit determination is made in order to give You a reasonable opportunity to respond prior to such final determination.

The Plan will see to it that all claims/appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

Upon request, the Plan will provide You notice of available internal claims and appeals and external review procedures in a culturally and linguistically appropriate manner, if applicable. Any notice given subsequent to such request shall be made in the same manner.

The Plan will provide You with continued coverage pending the outcome of an internal appeal.

STAGE 2 APPEAL: INTERNAL If You wish to appeal the Stage 1 Appeal decision, You may do so in writing. A decision on a Stage 2 Appeal will be sent to You or Your representative in writing within 72 hours for pre-service Urgent Care claims, 15 days for pre-service claims and 30 days for post-service claims from receipt of the Stage 2 Appeal. If the Stage 2 Appeal is denied, then **You** and/or Your provider will be provided with written notification of the denial and the reasons for the denial and an explanation outlining Your right to proceed to an **External Review Process** and a description of that process.

STAGE 3 APPEAL: EXTERNAL REVIEW PROCESS. The Plan provides for an external review process in accordance with recent changes in Federal Law related to the implementation of the PPACA, including any interim or final rules. Should there be any revisions to the Federal Law impacting the appeal process, this Plan will follow the new provisions, where required, and You will be notified of any changes made to this Plan as a result thereof. You will be provided with detailed information regarding the External Review Process once You have exhausted the Plan's Internal Appeal Process. In general, however, the external review process will provide for the following:

- A description of how a claimant may initiate an external review, procedures for preliminary review to determine whether a claim is subject to external review and minimum qualifications for the Independent Review Organization (IRO) that will be used as part of the process;
- A process for approving IROs eligible to be assigned to conduct external reviews and a process for random assignment of external reviews to approved IROs;
- Standards for IRO decision-making;
- Rules for providing notice of a final external review decision;
- An expedited review process (available only upon request of the claimant) for an adverse benefit determination that involves a medical Condition of a claimant in which a decision on the claim within the normal time frame would seriously jeopardize the life, health or ability of such claimant to regain maximum function;
- An explanation that, except to the extent other remedies are available under State or Federal law, an external review decision is binding on the Plan, as well as the claimant;
- Consumer protections to ensure that adequate clinical and scientific experience and protocols are taken into account; and
- An explanation of the information considered and relied upon in making any adverse benefit determination.

The Plan may charge You a filing fee to initiate an external review as permitted by Federal Law. You will be provided with information on the cost, if any, upon completion of the internal appeal process.

NOTICES OF DETERMINATION (applicable at all stages of the Appeals/External Review processes). Any decisions on Your appealed claim will be communicated to You or Your representative in writing or electronically. In the notice, You will be provided:

- the specific reasons for the determination;
- a reference to specific Plan provisions on which the decision was based;
- a statement informing You of Your rights to receive, upon request and at no charge, access to and copies of all documents, records and other information relevant to the claim; and
- a description of any additional, voluntary appeal procedures (if any) the Plan offers and of Your right to obtain information about the procedures.

If the decision was made based on an internal rule, guideline, criterion or other protocol of the Plan, You will be provided the specific rule, guideline, criterion or other protocol relied on, or You will receive a statement that such rule, guideline, criterion or other protocol is available at no charge, if You request a copy.

If the basis of the Plan's denial of Your appealed claim is Medically Necessary and Appropriate, experimental treatment or other similar exclusion or limitation, You will receive either:

- an explanation of the scientific or clinical judgment used in applying the Plan terms to Your medical circumstances; or
- a statement that such an explanation will be provided to You at no charge, if You request a copy.

If the external review process results in a denial of Your claim, in whole or in part, then You may have the right to bring civil action under ERISA Section 502(a).

OTHER (NON MEDICAL JUDGMENT) APPEALS

The Plan also has a procedure for resolving disputes between You and the Plan regarding matters that do not involve medical judgment. Such matters include any determination that involves only contractual or legal interpretation, without any use of medical judgment.

There are two (2) levels of appeal under this Plan for such administrative matters. Both levels are mandatory and must be exhausted prior to bringing civil action under ERISA Section 502(a) against the Plan.

- STAGE 1 APPEAL: Direct Your initial inquiry to the Plan Administrator. If You are dissatisfied with the response to Your inquiry, You may appeal in writing to the Plan Administrator's Appeals Department for an initial Administrative Appeal review. Presentation of a complaint should be in writing and may include written information from You or any other party in interest. This should be done as soon as possible but in no event later than 180 days from the date of the inquiry. A Plan representative will review Your appeal/grievance and respond in writing within 30 days.

- STAGE 2 APPEAL: If You wish to appeal the Stage 1 Appeal decision, You may do so by submitting Your Stage 2 Appeal in writing to the Plan Administrator's Appeals Department within 30 days of Your receipt of the Stage 1 Appeal decision. The Plan's Benefits Review Committee for Stage 2 Appeals will review the Stage 1 Appeal decision and will respond to You in writing within 30 days of receipt of Your Stage 2 Appeal. Stage 2 Appeal forms are available upon request. The decision of the Plan's Benefits Review Committee for Stage 2 Appeals will be binding. No external review process is available in the case of administrative, i.e., non-medical-judgment-related claims.

COORDINATION OF BENEFITS

COORDINATION OF BENEFITS

If You Are Covered by More Than One Medical Plan

A Covered Person may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by the Plan as an Employee and by another Plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows the Plan to coordinate what the Plan pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the Primary Plan and which is the Secondary Plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all plans under which the Covered Person is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Covered Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the plans involved, except where a statute requires another definition, or as otherwise stated below.

When the Plan is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription Drugs or hearing aids, Allowable Expense is limited to like items of expense.

The Plan will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When the Plan is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Plan will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or portion of a Calendar Year, during which a Covered Person is covered by the Plan and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

a) Group insurance and group Subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
d) Group Hospital indemnity benefit amounts that exceed $150 per day;
e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or non-governmental plan.

Plan does not include:

a) Individual or family insurance contracts or Subscriber contracts;
b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
c) Group or group-type coverage where the cost of coverage is paid solely by the Covered Person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a plan;
d) Group Hospital indemnity benefit amounts of $150 per day or less;
e) School accident –type coverage;
f) A State Plan under Medicaid.

Primary Plan: A Plan whose benefits for a Covered Person's health care coverage must be determined without taking into consideration the existence of any other plan. There may be more than one primary plan. A Plan will be the primary Plan if either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits provision; or
b) All plans which cover the Covered Person use order of benefit determination rules consistent with those contained in this Coordination of Benefits provision and under those rules, the Plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by **the Plan**, based on a standard which is most often charged for a given service by a provider of services within the same geographic area.

Secondary Plan: A Plan which is not a primary plan. If a Covered Person is covered by more than one secondary plan, the order of benefit determination rules of this Coordination of Benefits provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each secondary Plan may take into consideration the benefits of the primary Plan or plans and the benefits of any other Plan which, under this Coordination of Benefits provision, has its benefits determined before those of that secondary plan.

PRIMARY AND SECONDARY PLAN

The Plan considers each Plan separately when coordinating payments.

The primary Plan pays or provides services or supplies first, without taking into consideration the existence of a secondary plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the primary plan.

A secondary Plan takes into consideration the benefits provided by a primary Plan when, according to the rules set forth below, the Plan is the secondary plan. If there is more than one secondary plan, the order of benefit determination rules determine the order among the secondary plans. During each Claim Determination Period the secondary plan(s) will pay up to the remaining unpaid allowable expenses, but no secondary Plan will pay more than it would have paid if it had been the primary plan. The method the secondary Plan uses to determine the amount to pay is set forth below in the **"Procedures to be Followed by the Secondary Plan to Calculate Benefits"** section of this provision.

The secondary Plan shall not reduce Allowable Expenses for Medically Necessary and Appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Covered Person as an Employee, Member, Subscriber or retiree shall be determined before those of the Plan that covers the Covered Person as a Dependent. The coverage as an Employee, Member, Subscriber or retiree is the primary plan.

The benefits of the Plan that covers the Covered Person as an Employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Covered Person as a laid off or retired Employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Covered Person as an Employee, Member, Subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Covered Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a Child is covered as a Dependent under plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of Plan which covered the other parent for a shorter period of time.
c) Birthday, as used above, refers only to month and day in a Calendar Year, not the year in which the parent was born.
d) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a Child is covered as a Dependent under plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the Child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the Child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the primary plan, the benefits of the Plan that covers the Employee, Member or Subscriber for a longer period of time shall be determined before the benefits of the plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

a) the basis on which the primary Plan and the secondary Plan pay benefits; and

b) whether the provider who provides or arranges the services and supplies is in the network of either the primary Plan or the secondary plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Covered Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Reasonable and Customary charge is called an "R&C Plan."

Benefits may be based on a contractual Fee Schedule, sometimes called a negotiated Fee Schedule, or some similar term. This means that although a provider, called a Network Provider, bills a charge, the Covered Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated Fee Schedule is called a "Fee Schedule Plan." If the Covered Person uses the services of a non-Network Provider, the Plan will be treated as an R&C Plan even though the Plan under which he or she is covered allows for a Fee Schedule.

Payment to the provider may be based on a "capitation". This means that then HMO or other plans pays the provider a fixed amount per Covered Person. The Covered Person is liable only for the applicable Deductible, coinsurance or copayment. If the Covered Person uses the services of a non-Network Provider, the HMO or other plans will only pay benefits in the event of Emergency care or Urgent Care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network Provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the Fee Schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the Fee Schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or Deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a Network Provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) the difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Covered Person shall only be liable for the copayment, Deductible or coinsurance under the Secondary Plan if the Covered Person has no liability for copayment, Deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or Deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a Network Provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the Fee Schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO Plan that does not allow for the use of non-Network Providers except in the event of Urgent Care or Emergency care and the service or supply the Covered Person receives from a non-Network Provider is not considered as Urgent Care or Emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Covered Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any Deductible, coinsurance or copayment required by the Primary Plan; or
b) the amount the Secondary Plan would have paid if it had been the Primary Plan.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

If You need medical or dental care as a result of an automobile related Injury, the Plan provides either primary or secondary coverage to "personal Injury protection coverage" (PIP) provided as part of an automobile insurance policy issued in New Jersey. You choose which Plan You want to be primary when You sign up for automobile insurance.

The option to designate this Plan as primary applies to the named Insured and resident relatives who are not themselves the named Insureds under another automobile insurance policy and are formally covered by this Plan. The option does not apply to any guest, passenger, or pedestrian unless they are the named insured or resident relative of the insured. Upon renewal or purchase of a New Jersey auto insurance policy, the auto insurance carrier will provide a Coverage Selection Form for the insured to designate their choice for their primary payer on auto related medical expenses.

The Plan is a secondary payer to "out-of-state automobile insurance coverage" (OSAIC), unless You choose otherwise, or OSAIC or a law of the state in which the OSAIC is issued contains provisions which would require this Plan to pay its benefits before OSAIC does.

If there is a dispute as to which Plan is primary, the Plan will pay benefits for eligible expenses as if it were primary.

When this Plan is selected as the primary payer, the liability for these services will be covered to the same extent as any other service and subject to all of the applicable contract provisions and limitations. The automobile insurer providing PIP medical expense coverage will be liable for reasonable medical expenses not covered by the health plan, up to the limit of the insured's PIP medical expense benefit coverage.

When this Plan is selected as the secondary payer, this Plan will be liable for the Deductible, coinsurance and eligible expenses not covered by PIP within the cap chosen by the insured and eligible expenses above the PIP cap to the same extent as any other service and subject to all of the applicable contract provisions and limitations.

The coordination of benefits provision of the Plan will apply in the following circumstances:

- You are covered under more than one plan; and
- the Plan is primary to automobile insurance coverage.

COORDINATION WITH MEDICARE

MEDICARE AS SECONDARY PAYOR
IMPORTANT NOTICE

This Plan is treated as a large Employer Plan for purposes of "Medicare as Secondary Payor" rules. Regardless of whether Your Employer has between 2-19 Employees and would not normally be subject to "Medicare as Secondary Payor" rules, this "Medicare as Secondary Payor" rule will apply to all enrolled Participants of the Trust.

The following provisions explain how the Plan's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a) "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVI of the United States Social Security Act, as amended from time to time.
b) A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c) A "primary" health Plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" Plan pays. A "secondary" health Plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section above for a definition of "Allowable Expense".

MEDICARE ELIGIBILITY BY REASON OF AGE
(Applies to all enrolled Participants of the Trust)

Applicability
This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age. Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:
a) a Covered Person, other than an Employee or insured spouse
b) an Employee or insured spouse who is under age 65, or
c) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare
When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A) - The Medicare eligible may choose this Plan as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Plan is Primary** section below, for details.

Option (B) - The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Plan will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, the Plan will pay benefits as if he or she had chosen Option (A).

When the Plan is Primary
When a Medicare eligible chooses the Plan as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Plan and Medicare, the Plan is considered primary. The Plan pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary
If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Plan. Coverage under the Plan will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Plan as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY
(Applies to all enrolled Participants of the Trust)

Applicability
This section applies to a Covered Person who is:
a) under age 65; and
b) eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:
a) a Covered Person who is eligible for Medicare by reason of age; or
b) a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare
When a Covered Person becomes eligible for Medicare by reason of disability, the Plan is the primary plan. Medicare is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B of Medicare. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Plan.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE
(Applies to all enrolled Participants of the Trust)

Applicability
This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Plan and Medicare, the Plan is considered primary. The Plan pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 30-month period begins on the earlier of:

a) the first day of the month during which a regular course of renal dialysis starts; and
b) with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 30-month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Plan and Medicare, Medicare is the primary plan. The Plan is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B of Medicare. Benefits will be payable as specified in the **COORDINATION OF BENEFITS** section of the Plan.

If You are affected by this provision of the Plan, You can call the Plan at 1-888-670-8135 for more information.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this Provision Applies.
A Covered Person may incur medical charges due to injuries caused by the act or omission of a third party and/or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical charges.

Reimbursement/Refund Rights.
As a Condition of receiving benefits under this Plan, a Covered Person automatically assigns and transfers to this Plan any rights the Covered Person may have to recover payments from any third party or insurer (including, but not limited to such Covered Person's own insurer(s)), for funds paid or payable under this Plan as a result of personal Injury or reimbursement of medical expenses. Further, in the event the Covered Person receives any funds from a judgment, settlement or otherwise from any other person, business entity or any other source, the Covered Person shall first repay this Plan in full as the first priority party, for any benefits paid by this Plan.

Subrogation Rights.
As a Condition of receiving benefits under this Plan, a Covered Person recognizes, transfers, conveys and otherwise authorizes this Plan to directly pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person or Dependent chooses to pursue that claim.

Plan's Priority Over Funds.
The Covered Person agrees to recognize this Plan's right to subrogation and reimbursement. These rights provide this Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. This priority shall be enforceable even if the Covered Person is not made whole by the available recoveries, and shall be considered a lien against such recoveries until this Plan is repaid in full.

Amount Subject to Subrogation or Refund.
This Plan's priority to funds, subrogation and refund rights, and any/all rights assigned to it, is limited to the extent to which this Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under this Plan.

Agreement to Assist In Enforcing Rights.
Covered Person(s) under this Plan agree to: (1) inform this Plan in writing within sixty (60) days of their claim against third parties, entities and/or insurers for benefits; (2) furnish information and assistance regarding the existence and status of such claims; and (3) to execute any documents as this Plan may require to enforce its rights under this Plan. Covered Persons also agree to take no action which may prejudice the rights or interest of this Plan with respect to third party recovery.

Failure to comply with these provisions will be considered a material breach of a Covered's Person's obligations under the Plan and may result in the Covered Person(s) being personally responsible for reimbursing the Plan, and/or lead to a denial of all further Plan benefits.

CONTINUING COVERAGE

The following CONTINUATION COVERAGE RIGHTS UNDER COBRA section may not apply to the Employer's coverage. The Employee must contact his or her Employer to find out if the Employer is subject to the CONTINUATION COVERAGE RIGHTS UNDER COBRA section. If so, the following section applies to the Employee. (This section only applies to Employer groups with 20 or more Employees. COBRA Continuation coverage does not apply for Groups with fewer than 20 Employees – refer to page 70 for continuation options for Groups with fewer than 20 Employees.)

The Plan Administrator is QualCare, Inc. The COBRA Plan Administrator is OCA Benefits Services (OCA). OCA is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?
COBRA continuation coverage is the temporary extension of Group Health Plan coverage that must be offered to certain Plan Participants and their eligible family Members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?
In general, a Qualified Beneficiary can be:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees but also any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, inDependent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?
A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and Conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.
(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
(iv) A covered Employee's enrollment in any part of the Medicare program.
(v) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and Conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12-months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other Conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage Conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note: that the covered Employee and family Members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage?
The Plan has Conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?
The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family Members, but only within a limited period of 60 days or less and only during the six months immediately after their Group Health Plan coverage ended. Any person who qualifies or thinks that he and/or his family Members may qualify for assistance under this special provision should contact the COBRA Plan Administrator for further information.

Is a covered Employee or Qualified Beneficiary responsible for informing Qualcare of the occurrence of a Qualifying Event?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after QualCare has been timely notified that a Qualifying Event has occurred. The Employer will notify QualCare of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the Employee,
- commencement of a proceeding in bankruptcy with respect to the Employer, or
- enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You or someone on Your behalf must notify QualCare in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to QualCare during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to QualCare, Inc.

NOTICE PROCEDURES:

Any notice that You provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver the notice to:

QualCare, Inc. – MEWA Department
30 Knightsbridge Road
Piscataway, NJ 08854
Fax: 732-465-7328

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state:

- the ***name of the Plan or plans*** under which You lost or are losing coverage,
- the ***name and address of the Employee*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, Your notice must include ***a copy of the divorce decree or the legal separation agreement***. There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, ***"How does a Qualified Beneficiary become entitled to a disability extension?"*** That explanation describes other situations where notice from You or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once QualCare receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If You or Your spouse or Dependent Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to OCA, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any Group Health Plan (including a successor plan) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29-months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?
The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18-months after the Qualifying Event, if there is not a disability extension, and 29-months after the Qualifying Event, if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36-months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18-months (or 29-months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(iv) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36-months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36-months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36-months after the date of the first Qualifying Event. OCA must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to OCA.

How does a Qualified Beneficiary become entitled to a disability extension?
A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the OCA with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to OCA.

Does the Plan require payment for COBRA continuation coverage?
For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either 1) under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or 2) under the terms of an arrangement

between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a Qualified Beneficiary be given the right to enroll in a conversion health Plan at the end of the maximum coverage period for COBRA continuation coverage?
The Plan does not offer a conversion option, therefore, a conversion option is not available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact OCA **or Your Employer** or You may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

KEEP YOUR EMPLOYER AND/OR QUALACARE INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep QualCare and Your Employer informed of any changes in the addresses of family Members. You should also keep a copy, for Your records, of any notices You send to the QualCare or Your Employer.

NEW JERSEY CONTINUATION

New Jersey has a continuation requirement similar to COBRA, but one that's applicable to small Employers, i.e., those having 2 to 19 Employees (including Part-Time Employees) **N.J.S.A. 17B:27A-27 (as amended by P.L.2004, c.162).** Every small Employer in New Jersey offering coverage to its Employees shall offer continued coverage under the Plan to any Employee who experiences a Qualifying Event, as defined below.

What is a Qualifying Event?
A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage in the absence of continuation coverage:

(a) termination of employment, for a reason other than for cause;
(b) a reduction in an Employee's hours of employment (to less than 25) becomes effective;
(c) death of the Employee;
(d) the divorce of the Employee from the Employee's spouse; or
(e) Dependent Child ceases to be an eligible Dependent.

How do I elect Continuation Coverage?
At the time of the Qualifying Event, OCA must notify You in writing, of:

a) Your right to continuation of the Plan's group health benefits;
b) the monthly contribution You must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

You must also send a written request to OCA that You elect continuation coverage within 30 days of the occurrence of the qualifying event.

Does the Plan require payment for Continuation Coverage?
The Plan requires payment of contributions by the Employee, spouse or Dependent Child for any period of continuation coverage as provided for in this section, except that the contribution shall not exceed 102%, or 150% in the case of continuation of coverage for disability, of the applicable contribution (both the Employer- and Employee-paid amounts) paid for similarly situated beneficiaries under the Plan. Payment may, at the election of the payor, be made in monthly installments. No payment shall be due before the 30th day after the day on which the covered Employee made the initial election for continued coverage. Payments must be paid to OCA at the times and in the manner the Plan specifies.

If You fail to give the Employer notice that You elect to continue or fail to make any premium payment in a timely manner, You waive Your continuation rights. All payments will be considered timely if they are made within 31 days of the specified due dates.

Who can become a Qualified Beneficiary?
In general, a Qualified Beneficiary can be:

(a) Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day a covered Employee.
(b) any spouse who is a Qualified Beneficiary under the Plan by reason of being the spouse of a covered Employee on the day before the Qualifying Event;
(c) to any Dependent Child who is a Qualified Beneficiary under the Plan by reason of being the Dependent Child of a covered Employee on the day before the Qualifying Event, subject to the applicable terms of the Plan; and
(d) to any such spouse or Dependent Child who is a Qualified Beneficiary under the Plan whenever that spouse or Dependent Child is no longer entitled to coverage under the Plan by reason of the death of the Employee or the divorce of the Employee from the spouse.

What Benefits Can Be Continued?
Coverage can be continued which is identical to the coverage provided under the Plan to similarly situated Qualified Beneficiaries. If coverage is modified under the Plan for any group of similarly situated Qualified Beneficiaries, this continuation coverage shall also be modified in the same manner for persons who are Qualified Beneficiaries. Continuation of coverage may not be Conditioned upon, or discriminate on the basis of, lack of evidence of insurability.

What are the maximum coverage periods for continuation coverage?
The maximum time coverage can be continued is 6 months.

Under what circumstances can the maximum coverage period be expanded?
Continuation of coverage provided for under this section shall not exceed 18 months from the qualifying event, except that:

(1) In the case of a spouse or Dependent Child who is a Qualified Beneficiary, continuation of coverage shall extend until the date 36 months after the date the spouse's or Dependent Child's benefits under the Plan would otherwise have terminated by reason of the death of the Employee, the divorce of the Employee from the spouse or a Dependent Child ceasing to be a Dependent Child under the applicable provisions of the Plan; and

(2) In the case of an Employee who is determined to have been disabled under Title II or XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) at the time of termination of employment or at any time during the first 60 days of continuation of coverage, continuation of coverage shall extend until 29 months after the date benefits under the Plan would have terminated; provided, however, that if the Employee is no longer disabled, continuation of coverage shall terminate on the later date of 18 months or the month that begins more than 31 days after the date of final determination under Title II or Title XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) that the Employee is no longer disabled. The Employee shall provide notification of the disability determination under Title II or XVI of the Social Security Act (42 U.S.C.ss.401-433 or 42 U.S.C.ss.1381-1383) to the Plan within 60 days of the date of that determination, and within 18 months of the date benefits under the Plan would have terminated.

When may a Qualified Beneficiary's continuation coverage be terminated?
Coverage continued pursuant to this section shall continue until the earliest of the following:

(1) The date upon which the Employer under whose Health Benefits Plan coverage is continued ceases to provide any Health Benefits Plan to any Employee or other Qualified Beneficiary;

(2) The date on which the continued coverage ceases under the Plan by reason of a failure to make timely payment of any contribution required under the Plan by the former Employee, spouse, or Dependent Child having the continued coverage. The payment of any contribution shall be considered to be timely if made within 30 days after the due date or within such longer period as may be provided for by the Plan; or

(3) The date after the date of election on which the Qualified Beneficiary first becomes:

(a) Covered under any other Health Benefits Plan, as an Employee or otherwise, which does not contain a provision which limits or excludes coverage of a covered Employee or any spouse or Dependent Child who is included under the coverage provided the covered Employee, for such period of the limitation or exclusion; or

(b) Entitled to Medicare after electing continued coverage.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN SPONSOR. The Plan is sponsored by the **Affiliated Physicians & Employers Health Plan.**

PLAN ADMINISTRATOR. The Plan is administered by the **Affiliated Physicians & Employers Health Plan.** The day-to-day operation of the Plan is managed by QualCare Alliance Networks, Inc. as its authorized delegate. However, the **Affiliated Physicians & Employers Health Plan** has sole and final Discretion and authority to determine eligibility for benefits, and to interpret provisions of the Plan. The Plan Administrator may allocate or delegate certain functions as it deems appropriate. Benefits under the Plan will be paid only if the Plan Administrator (or its authorized delegate) decides in its Discretion that under the terms of the Plan the applicant is entitled to the benefit. The decisions of the Plan Administrator or its delegate are final and binding.

Service of legal process may be made upon the Plan Administrator.

DUTIES AND AUTHORITY OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms and consistent with applicable law. To establish, administer and enforce policies, interpretations, practices and procedures in connection with its duties.

(2) To make decisions and determinations regarding the interpretation or application of the Plan and Plan provisions, and to decide all other matters arising with respect to the Plan's administration and operation, including factual issues and the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To determine the rights, eligibility, and benefits of Participants and beneficiaries under the Plan, including deciding disputes which may arise relative to a Plan Participant's rights. Benefits under this Plan will be paid only if the Plan Administrator, or its designee or delegate decides in its Discretion that the applicant is entitled to them.

(4) To describe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical Child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan Sponsor.

FIDUCIARY. A fiduciary exercises Discretionary authority or control over management of the Plan or the disposition of its assets, has Discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan's governing document(s). If such document(s) does not indicate the named fiduciary(ies), the Plan Sponsor shall be the named fiduciary. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a Trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR. A Claims Administrator is **not** a fiduciary under the Plan solely by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN FUNDING AND PAYMENT OF BENEFITS. The Plan does not have a dedicated source of funding. The funding for the benefits is derived from the healthcare fees charged to each Participating Employer and any contributions, if any, made by covered Employees. The Plan is not insured. The level of any Employee contributions will be set by each Participating Employer. Benefits are generally paid through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN. The Plan Administrator expects to continue the Plan, but necessarily reserves the right at any time, by or pursuant to action of its authorized officer(s) or other personnel to amend or terminate the Plan in any and all respects including without limitation, the right to amend the Plan to reduce, change, eliminate and/or modify the type or amount of coverage or benefits provided to any class of Covered Persons receiving or entitled to receive benefits, including the cost of benefits to such individual, without prior notice to such individuals. Upon termination of the Plan, all elections relating to the Plan will terminate, and reimbursements and payments with respect to Plan benefits will be made only with respect to Claims for expenses incurred on or prior to the date of the Plan's termination.

Any amendments to this Plan will be in writing.

ERISA RIGHTS

YOUR RIGHTS UNDER ERISA

As a participant in the Plan described in this booklet, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, if any, and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, if any, and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continued health care ("COBRA") coverage for Yourself, Your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing Your COBRA coverage rights.
- You should be provided with a certificate of Creditable Coverage, free of charge, from Your Group Health Plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your Employer, Your union, if any, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials we re not sent because of reasons beyond the control of the Plan Administrator.

If You have a claim for benefits which is denied or ignored, in whole or in part, You may file a suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical Child support order, You may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

If You have any questions about the Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or:

The Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Upon written request Plan participants may receive from the Plan Administrator as to whether a particular Employer or Employer organization is a sponsor of the Plan and if the Employer or Employee organization is a Plan Sponsor, the sponsor's address.

The name, title and address and the principal place of business of each Trustee of the Plan are available upon written request.

FUTURE OF THE PLAN

While the Trust expects to continue the Plan as outlined in this booklet, the Trust reserves the right to terminate, modify or amend it at any time without notice. Any claims submitted after the Effective Date of termination, modification or amendment are payable in accordance with the revised Summary Plan Description. In the event that the Plan terminates, You will be informed of any termination rights You may have.

The Plan is a self-funded health Plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the healthcare fees charged to each Participating Employer and any contributions, if any, made by covered Employees. The Plan is not insured.

PLAN ADMINISTRATION INFORMATION

PLAN SPONSOR	The Affiliated Physicians and Employers Master Trust
PLAN NUMBER	501
PLAN NAME	The Affiliated Physicians and Employers Health Plan
ADDRESS OF PLAN	30 Knightsbridge Road Piscataway, NJ 08854
TAX IDENTIFICATION NUMBER	45-6416517
PLAN ADMINISTRATOR	QualCare, Inc. 30 Knightsbridge Road Piscataway, NJ 08854
CLAIMS ADMINISTRATOR	QualCare, Inc.
UTILIZATION REVIEW ADMINISTRATOR	QualCare, Inc.
NAMED FIDUCIARY	The Affiliated Physicians and Employers Master Trust / QualCare, Inc.
AGENT FOR SERVICE OF LEGAL PROCESS	The Affiliated Physicians and Employers Master Trust / QualCare, Inc.
PLAN ADMINISTRATOR FOR COBRA PURPOSES	QualCare, Inc.

IMPORTANT PLAN EFFECTIVE DATES

Plan Effective Date:	January 1, 2004	
Plan Benefit Year:	January 1st through December 31st	
Plan Renewal Date:	This Plan has four (4) renewal dates: January 1st or April 1st or July 1st or October 1st *Depending on when Your Employer first elected coverage.*	
Plan's Annual Open Enrollment:	For January Renewals: For April Renewals: For July Renewals: For October Renewals:	December 1 - December 31 March 1- March 31 June 1 - June 30 September 1 - September 30
Date of Last Restatement/Revision:	January 1, 2013	

NOTES

Administered by:

Toll Free: (888) 670-8135
www.qualcareinc.com/qcmewa

AFFILIATED PHYSICIANS & EMPLOYERS HEALTH PLAN
PLAN D – FACILITY HIGH DEDUCTIBLE PLAN
How the Plan Works

Participating Provider Plan

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers or Network Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse them at a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

How to Identify Participating Providers

You can find the Plan's Participating Providers at the Plan's website at www.qualcareinc.com/qcmewa or by calling the Plan hotline at 1-888-670-8135.

How the Plan Works

You choose a **NETWORK PROVIDER** or an **OUT-OF-NETWORK PROVIDER** each time you need medical attention.

- **NETWORK PROVIDERS**
  - **For NJ Residents** - the Network consists of physicians, specialists, hospitals and facilities throughout New Jersey who participate in the QualCare Regional PPO Network.
  - **For out of area care-** the Network consists of physicians, specialists, hospitals and facilities who participate in the QualCare Regional PPO Network in NJ and the First Health Network outside the state of New Jersey.
  - **For those members that purchased the Wrap Around Network Option** (refer to your ID Card for wraparound network information)- the Network consists of physicians, specialists, hospitals and facilities who participate in the QualCare Regional PPO Network in NJ, First Health Network and GHI Network in New York.

  Network providers charge you a preferred rate for services and treatment. In most cases, you pay a small copayment to your network provider. Other times, services are covered at 100%. Facility services will be applied to the Facility Deductible and must be satisfied before any facility services are reimbursed.

- **OUT-OF-NETWORK PROVIDERS** are physicians, specialists, hospitals and facilities that charge you their regular fees for services and treatment. You are reimbursed for a percentage of the *Plan's Allowable Charges* once you meet your *Deductible*. Please note that when using Out-of-Network Providers your out-of-pocket expense will be higher.

In general, the Plan pays a higher level of benefits when you use Network providers.

How You Pay for Services

How you pay for services depends on whether you receive care from a Network Provider or an Out-of-Network Provider.

- **Network Providers** — Simply show your Plan identification card to your Network provider and pay the required copayment. Your provider will bill the Plan directly for services rendered.

- **Out-of-Network Providers** — When you choose to use providers that are not part of the network, you will be required to meet the Deductible before the Plan pays benefits. In addition, you may be required to pay the provider in full and then submit the bill for reimbursement. In general, you are reimbursed 70% of the Plan's Allowable Charges after you meet your Deductible.

Definitions You Need to Know

Plan's Allowable Charges are charges that do not exceed the maximum dollar amount the Plan will recognize for a covered service, procedure or supply by other network providers of similar profession.

- Charges in excess of the *Plan's Allowable Charges* are not considered covered charges under the Plan and do not accrue towards your maximum Out-of-Pocket allowance.
- You are responsible for any amounts above the Plan's *Allowable Charges* when utilizing out-of-network providers.

PLAN D – FACILITY HIGH DEDUCTIBLE PLAN
SCHEDULE OF BENEFITS
PPO Plan - No Referrals Required to see a Specialist

Benefit/Feature	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
Deductible (every Plan Benefit Year) - Facility Deductible	$2,500/individual; $5,000/family (Combined In/Out)	
- All Other Services	None	Deductible applies for **ALL** services
Out-of-Pocket Maximum (every Plan Benefit Year)	$6,350/individual; $12,700/family	$6,350/individual; $12,700/family
*(**Out of Pocket Maximum** is cumulative in network and out-of-network and **includes deductible, coinsurance and medical copayments** but does not include prescription, non covered amounts above the plan's fee schedule or allowable charge, or pre-authorization penalties.)*		
Lifetime Maximum Benefit	Unlimited	Unlimited

Physician Office Visits	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
PCP or Specialist Office Visit	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges[1]
Gynecological Care - *Routine* - *Non-Routine*	Plan pays 100% You pay $15 copay/visit	Not Covered After deductible, plan pays 70% of Plan's Allowable Charges [1]
Pre-Natal Care	You pay $15 copay (initial visit only)	After deductible, plan pays 70% of Plan's Allowable Charges [1]
Consultations/Second Opinions	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges[1]
Allergy Injections - W/ Office Visit - W/out Office Visit	You pay $15 copay/visit Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges [1]
Well-Woman Care *Refer to Routine Wellness Schedule*	Plan pays 100%	Routine care not covered
Mammography **Routine** *(Hospital, Facility, Physician)* **Non-Routine** *(Hospital)* **Non-Routine** *(Free Standing Facility)* **Non-Routine** *(Physician)* *Refer to Routine Wellness Schedule*	 Plan pays 100% Deductible, then 100% You pay $15 copay/visit You pay $15 copay/visit	 Routine care not covered Deductible, then 70% Deductible, then 70% Deductible, then 70%
Adult Wellness Exams *Refer to Routine Wellness Schedule*	Plan pays 100%	Routine care not covered
Well-Child Care *Refer to Routine Wellness Schedule*	Plan pays 100%	Routine care not covered
Influenza Vaccine	Plan pays 100%	Routine care not covered
Wellness coverage includes reimbursement for routine physical examinations, including related lab tests and x-rays, routine gynecological examination, mammography, pap smear, routine prostate screening & antigen test, glaucoma tests and recommended immunizations as shown in the following Routine Wellness Schedule on page 27.		
* These Services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of $10,000 will be applied. See page 40 for complete pre-authorization list.		
[1] For all Out-of-Network elective and non-emergent physician, hospital, and ancillary services, the Plan will not pay more than the Plan's Allowable charge. For all Out-of-Network elective and non-emergent Hospital services, the Plan will not pay more than the Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule for inpatient services and 125% of the Hospital's cost to charge ratio for outpatient services. Refer to definition of Plan's Allowable Charges on page 51 of the Summary Plan Description.		

Emergency Services	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
Emergency Room Services - Facility Charges - Ancillary Charges - Physician Charges	 $50 copay (waived if admitted) Plan pays 100% Plan pays 100%	 $50 copay (waived if admitted) Plan pays 100% Plan pays 100%
Emergency Admission - Facility Charges - Ancillary Charges - Physician Charges	 Plan pays 100% after facility deductible Plan pays 100% Plan pays 100%	 Plan pays 100% after facility deductible Plan pays 100% Plan pays 100%
Diagnostic Services related to ER visit	Plan pays 100%	Plan pays 100%
Ambulance Services	Plan pays 100%	Plan pays 100%

Hospital Charges	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
Inpatient Care * *Semi-private hospitalization*	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Intensive Care Unit *	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Anesthesiologists Fees	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Surgeon Fees	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Outpatient Care	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Inpatient/Outpatient/Office Professional Services	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Outpatient Ambulatory Surgery* - *Physician* - *Hospital* - *Facility (Free-standing Surgical Ctrs)*	 Plan pays 100% Plan pays 100% after facility deductible Plan pays 100%	 After deductible, plan pays 70% of Plan's Allowable Charges(1) After deductible, plan pays 70% of Plan's Allowable Charges (1) Plan pays 70% of a Maximum Allowable of $1,000 per surgery, after deductible(1)
Pre-Admission Testing	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges (1)
Inpatient Physical Rehabilitation & Skilled Nursing* *(includes cognitive therapy*)*	Plan pays 100% after facility deductible ***(60 days per incident maximum)***	After deductible, plan pays 70% of Plan's Allowable Charges (1)

* These Services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of $10,000 will be applied. See page 40 for complete pre-authorization list.

(1) For all Out-of-Network elective and non-emergent physician, hospital, and ancillary services, the Plan will not pay more than the Plan's Allowable charge. For all Out-of-Network elective and non-emergent Hospital services, the Plan will not pay more than the Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule for inpatient services and 125% of the Hospital's cost to charge ratio for outpatient services. Refer to definition of Plan's Allowable Charges on page 51 of the Summary Plan Description.

Other Services	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
ABA Therapy Services *		
- *Hospital Based*	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges [1]
- *Office based or Freestanding*	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges[1]
The maximum benefit amount for any Covered Person in any benefit year through 2014 shall be $37,710.		
Outpatient Therapy Services *		
Includes: Physical, Occupational & Speech		
- *Hospital Based*	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges [1]
- *Office based or Freestanding*	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges[1]
	(All Therapies limited to 60 visits combined every Benefit Year)	
***Note: Physical, Occupational, and Speech therapy* are subjected to a SEPARATE calendar year limit for just Autism (60 visit per year)**		
Cardiac Rehabilitation *		
- *Hospital Based*	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges [1]
- *Office based or Freestanding*	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges [1]
	(36 visits every Benefit Year)	
Laboratory Services		
- *Hospital Based*	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges [1]
- *Office based or Freestanding*	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges [1]
Quest Diagnostics is the exclusive lab provider of QualCare. All other labs will be considered Out of Network, should coverage apply.		
Other Diagnostic Services		
*X-Rays/MRIs /CT Scans/PET scans */ MRAs **	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's Allowable Charges [1]
- *Hospital Based*		
- *Office based or Freestanding*	Plan pays 100%	After deductible, plan pays 70% of Plan's Allowable Charges [1]
Durable Medical Equipment *	Plan pays 100%	Not covered
Home Health Care *	Plan pays 100%	Not covered
	(60 visits every Benefit Year)/ not to exceed 4 hrs per visit)	
Home Infusion */ IV Therapy *		
(IV Therapy requires Pre-authorization with the exception of Chemotherapy administration in a Doctor's office)		
- *Hospital Based*	Plan pays 100% after facility deductible	Not covered
- *Office based*	You pay $15 copay/visit	
- *Home based*	Plan pays 100%	
Hospice Care *	Plan pays 100%	After deductible, plan pays 70% of Plan's allowable charges [1]
Spinal Manipulation/Chiropractic Care	You pay $15 copay/visit	Not Covered
(Covered age 18 and older only)	***(30 visit maximum every Benefit Year)***	
Infertility Services	Not Covered	
Orthotics *	Plan pays 100%	After deductible, plan pays 70% of Plan's allowable charges [1]
Prosthetics *	Plan pays 100%	After deductible, plan pays 70% of Plan's allowable charges [1]
Wigs *($500 lifetime maximum - only covered after chemotherapy or burns)*	Plan pays 100%	After deductible, plan pays 70% of Plan's allowable charges [1]
Podiatry Services *(Routine Services are not covered)*	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's allowable charges [1]

* These Services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of $10,000 will be applied. See page 40 for complete pre-authorization list.

[1] For all Out-of-Network elective and non-emergent physician, hospital, and ancillary services, the Plan will not pay more than the Plan's Allowable charge. For all Out-of-Network elective and non-emergent Hospital services, the Plan will not pay more than the Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule for inpatient services and 125% of the Hospital's cost to charge ratio for outpatient services. Refer to definition of Plan's Allowable Charges on page 51 of the Summary Plan Description.

Mental Disorder & Substance Abuse Services	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
Inpatient * **Mental Disorder/Substance Abuse**	Plan pays 100% after facility deductible	After deductible, plan pays 70% of Plan's allowable charges (1)
Outpatient * **Mental Disorder/Substance Abuse** *-Hospital Based* *-Office Based or Freestanding Facility*	Plan pays 100% after facility deductible You pay $15 copay/visit	After deductible, plan pays 70% of Plan's allowable charges (1)
* These Services require pre-authorization. For Network services, your physician should obtain pre-authorization for you, however, you are ultimately responsible for pre-authorization for all services (in or out-of-network), otherwise a penalty of 50% of the Plan's allowable amount, to a maximum of $10,000 will be applied. See page 40 for complete pre-authorization list.		
(1) For all Out-of-Network elective and non-emergent physician, hospital, and ancillary services, the Plan will not pay more than the Plan's Allowable charge. For all Out-of-Network elective and non-emergent Hospital services, the Plan will not pay more than the Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule for inpatient services and 125% of the Hospital's cost to charge ratio for outpatient services. Refer to definition of Plan's Allowable Charges on page 51 of the Summary Plan Description.		

Prescription & Vision Services	Network Providers QualCare Regional PPO Network	Out-of-Network Providers
Routine Vision Care	You pay $15 copay/visit	Not Covered
Non Routine Vision Care *Must meet Medical Necessity and Appropriateness*	You pay $15 copay/visit	After deductible, plan pays 70% of Plan's Allowable Charges (1)
	(1 Routine Eye Exam every Benefit Year)	
Prescription Drugs - Express Scripts *(Must use participating pharmacy)*	Refer to Prescription Benefit Summary on page 30	
See Prescription Drug section for list of non-covered prescription drugs.		
(1) For all Out-of-Network elective and non-emergent physician, hospital, and ancillary services, the Plan will not pay more than the Plan's Allowable charge. For all Out-of-Network elective and non-emergent Hospital services, the Plan will not pay more than the Plan's Allowable Charge which will be based on 125% of current year CMS Fee Schedule for inpatient services and 125% of the Hospital's cost to charge ratio for outpatient services. Refer to definition of Plan's Allowable Charges on page 51 of the Summary Plan Description.		
Note: Injectable drugs require pre-authorization for Medical Necessity and Appropriateness from the Pharmacy Benefit Manager, with the exception of Insulin.		

Confidentiality Is Essential
The Affiliated Physicians and Employers Health Plan considers confidentiality essential to health care. Any information about your condition, care or treatment is held in the strictest confidence. See page 4 for more information on Protected Health Information (PHI).

PRESCRIPTION BENEFIT PLAN SUMMARY

The Affiliated Physicians & Employers Health Plan offers its members comprehensive pharmacy coverage through Express Scripts

The following Prescription Drug Benefit Section applies for all Plans that have elected Prescription Coverage. Please contact your Employer or refer to your ID Card to see which Rx Option you are enrolled in.

PRESCRIPTION PLAN OPTIONS – Effective 07/1/14

RX Plan 1 - Available with all Medical Plans (Plans A-N)

Retail (30 day supply): $6 - Generic, $25 - Preferred Brand, $40 - Non Preferred Brand
Mail Order (90 day supply): $15 - Generic, $62.50 - Preferred Brand, $100 - Non Preferred Brand

RX Plan 2 - Available with all Medical Plans (Plans A-N)

Retail (30 day supply): $20 - Generic, $40 - Preferred Brand, $70 - Non Preferred Brand
Mail Order (90 day supply):$50 - Generic, $100 - Preferred Brand, $175 - Non Preferred Brand

RX Plan 3 - Available with all Medical Plans (Plans A-N)

Retail (30 day supply): Generic: - $15 copay / Brand - 50% copay (Min of $25 /Max of $500) *(50% copay applies to the contracted rate)*
Mail (90 day supply): Generic: - $37.50 copay / Brand - 50% copay (Min of $62.50 /Max of $1,250) *(50% copay applies to the contracted rate)*

RX Plan 4 - ONLY Available with Plans C, I, K & N
(This RX plan would be considered an IRS/HSA compatible RX plan.)

MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES
Retail (30 day supply): $6 - Generic, $25 - Preferred Brand, $40 - Non Preferred Brand
Mail Order (90 day supply): $15 - Generic, $62.50 - Preferred Brand, $100 - Non Preferred Brand

RX Plan 5 - ONLY Available with Plans C, I, K & N
(This RX plan would be considered an IRS/HSA compatible RX plan.)

MEMBER MUST MEET MEDICAL DEDUCTIBLE BEFORE COPAY APPLIES

Retail (30 day supply): Generic: - $15 copay after deductible / Brand - 50% copay after Deductible (Min of $25 /Max of $500) *(50% copay applies to the contracted rate)*

Mail (90 day supply): Generic: - $37.50 copay after deductible / Brand - 50% copay after Deductible (Min of $62.50 /Max of $1,250) *(50% copay applies to the contracted rate)*

RX Plan 6 - Available with all Medical Plans
(If No RX is selected, medical rates will increase 2%)

No RX Coverage

You can ONLY select one (1) Rx Option for each Medical Plan Option you select

All APEHP Prescription Programs have cost saving measures in place to ensure that both our Members and our Plan save the most on covered prescriptions.

• RRA, Refill Retail Allowance - Save by using the Mail Order Program. Mail order can save members significantly for long-term drugs. This program only allows members to fill long-term drugs three times at a participating retail pharmacy for the retail co-payment. After the third purchase, members will pay the Mail Order Co-payments for the 30 day retail supply. Members can avoid paying more by using the Express Scripts Pharmacy. Medications will be delivered right to them, and standard shipping is free. Once members get started, they can request refills easily by mail, online, or over the phone.
• PDST, Preferred Drug Step Therapy - Save by using Preferred Drugs. Many drug categories have multiple drugs that can treat the same condition. The Affiliated Physicians and Employers Health Plan requires members to fill certain preferred medications over other non preferred medications unless their physician indicates otherwise. If members fill non preferred medication without getting prior approval or having their physician contact Express Scripts, they will be responsible for the drug's entire cost.
• Save by using Generics. The Plan has a program in place to automatically fill your prescription with the low cost generic alternative to save both you and the Plan. If you request a brand-name mediation when a generic equivalent is available, you will pay the applicable co-payment, plus the difference in cost between the brand and the generic.

EXHIBIT B

C/A 40007228

2

Atlantic Shore Surgical Association
478 Brick Blvd.
Brick, NJ 08723
Phone: 732-701-4848 Fax: 732-701-1469

Legal Assignment of Benefits & Designation of Authorized Representative

I, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, Atlantic Shore Surgical Associates and all medical professionals, including physician assistants of this practice, including, but not limited to Steven Priolo, Jonathan Yrad, Tarun Bhandari, Eugene Zurkovsky, Francis Kelly, Anil Paluja, James Pasquariello, Jane Park, Godwin Ofilcwu, Rory Shepar, Govardhana Rao Yannam, Forrest Rubenstein (the "providers") as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefit claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

I have read and fully understand this agreement.

M L K

Signature of Insured / Guardian

11.11.16

Date

M L K

Print Name of Insured/Guardian

RECEIVED
JAN 27 2017
By the Appeals Dept.

RECEIVED NOV 14 2016

REDACTED 12402